Health Canada Santé Canada

Your health and safety... our priority. Votre santé et votre sécurité... notre priorité.

Health Canada

2014-15

Departmental Performance Report

The Honourable Dr. Jane Philpott, P.C, M.P.
Minister of Health

© Her Majesty the Queen in Right of Canada,
represented by the President of the Treasury Board, 2013

Catalogue No. H1-9/6E-PDF
ISSN 2368-3554

This document is available on the Treasury Board of Canada Secretariat[i] website

This document is available in alternative formats upon request.

Table of Contents

Minister's Message 1
Section I: Organizational Expenditure Overview 3
  Organizational Profile 3
  Organizational Context 4
  Actual Expenditures 17
  Alignment of Spending With the Whole-of-Government Framework 20
  Departmental Spending Trend 21
  Expenditures by Vote 22
Section II: Analysis of Programs by Strategic Outcome 23
  Strategic Outcome 1: A health system responsive to the needs of Canadians 23
  Program 1.1: *Canadian Health System Policy* 23
  Sub-Program 1.1.1: *Health System Priorities* 25
  Sub-Program 1.1.2: *Canada Health Act Administration* 27
  Program 1.2: *Specialized Health Services* 29
  Program 1.3: *Official Language Minority Community Development* 31
  Strategic Outcome 2: Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians 34
  Program 2.1: *Health Products* 34
  Sub-Program 2.1.1: *Pharmaceutical Drugs* 36
  Sub-Program 2.1.2: *Biologics & Radiopharmaceuticals* 38
  Sub-Program 2.1.3: *Medical Devices* 40
  Sub-Program 2.1.4: *Natural Health Products* 41
  Program 2.2: *Food Safety and Nutrition* 43
  Sub-Program 2.2.1: *Food Safety* 46
  Sub-Program 2.2.2: *Nutrition Policy and Promotion* 47
  Program 2.3: *Environmental Risks to Health* 49
  Sub-Program 2.3.1: *Climate Change and Health* 52
  Sub-Program 2.3.2: *Air Quality* 53
  Sub-Program 2.3.3: *Water Quality* 56
  Sub-Program 2.3.4: *Health Impacts of Chemicals* 57
  Program 2.4: *Consumer Product and Workplace Chemical Safety* 60
  Sub-Program 2.4.1: *Consumer Product Safety* 62
  Sub-Program 2.4.2: *Workplace Chemical Safety* 64
  Program 2.5: *Substance Use and Abuse* 65
  Sub-Program 2.5.1: *Tobacco* 68
  Sub-Program 2.5.2: *Controlled Substances* 70
  Program 2.6: *Radiation Protection* 72
  Sub-Program 2.6.1: *Environmental Radiation Monitoring and Protection* 74
  Sub-Program 2.6.2: *Radiation Emitting Devices* 76
  Sub-Program 2.6.3: *Dosimetry Services* 77
  Program 2.7: *Pesticides* 79

Strategic Outcome 3: First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status 82
Program 3.1: *First Nations and Inuit Primary Health Care* 82
Sub-Program 3.1.1: *First Nations and Inuit Health Promotion and Disease Prevention* 84
Sub-Sub Program 3.1.1.1: *Healthy Child Development* 86
Sub-Sub Program 3.1.1.2: *Mental Wellness* 88
Sub-Sub Program 3.1.1.3: *Healthy Living* 90
Sub-Program 3.1.2: *First Nations and Inuit Public Health Protection* 93
Sub-Sub Program 3.1.2.1: *Communicable Disease Control and Management* 95
Sub-Sub Program 3.1.2.2: *Environmental Public Health* 98
Sub-Program 3.1.3: *First Nations and Inuit Primary Care* 99
Sub-Sub Program 3.1.3.1: *Clinical and Client Care* 101
Sub-Sub Program 3.1.3.2: *Home and Community Care* 103
Program 3.2: *Supplementary Health Benefits for First Nations and Inuit* 105
Program 3.3: *Health Infrastructure Support for First Nations and Inuit* 107
Sub-Program 3.3.1: *First Nations and Inuit Health System Capacity* 109
Sub-Sub Program 3.3.1.1: *Health Planning and Quality Management* 111
Sub-Sub Program 3.3.1.2: *Health Human Resources* 113
Sub-Sub Program 3.3.1.3: *Health Facilities* 114
Sub-Program 3.3.2: *First Nations and Inuit Health System Transformation* 116
Sub-Sub Program 3.3.2.1: *Systems Integration* 118
Sub-Sub Program 3.3.2.2: *e-Health Infostructure* 120
Sub-Program 3.3.3: *Tripartite Health Governance* 122
Internal Services 124
Section III: Supplementary Information 127
Financial Statements Highlights 127
Financial Statements 129
Supplementary Information Tables 129
Tax Expenditures and Evaluations 129
Section IV: Organizational Contact Information 130
Appendix: Definitions 131
Endnotes 134

Minister's Message

It is a tremendous honour for me to have been named federal Minister of Health.

In the coming weeks and months, the Government will be advancing an ambitious health agenda. My overriding priority is to strengthen our publicly-funded universal health care system and ensure that it adapts to new challenges. To that end, I will be working with my provincial and territorial colleagues to support them in their efforts to make home care more available, prescription drugs more affordable, and mental health care more accessible.

The Government has also pledged a renewed, nation to nation relationship with Canada's Indigenous peoples. Continued progress by the First Nations and Inuit Health Branch to improve health services and develop innovative partnerships with First Nations and Inuit will be important to achieving the Government's pledge.

I will also be asking Health Canada to take important policy and regulatory actions to help Canadians lead healthier lives. This action will include introducing plain packaging for tobacco products; introducing new restrictions on the marketing of unhealthy food and drinks to children; bringing in tougher regulations to eliminate Trans fats and cut salt in processed foods; and improving food labels.

Sound, evidence-based policies will be essential to implementing the Government's agenda. Health Canada's dedicated scientific and policy experts are respected the world over. I will be looking to them for the high quality advice for which they are known.

The *2014-15 Departmental Performance Report* outlines Health Canada's actions last year to help the people of Canada maintain and improve their health. As Minister of Health, I look forward to moving ahead on my key mandate priorities in the coming year, by building a culture of collaboration and evidence-based decision-making that will strengthen health care, improve public health, and result in better health outcomes for all Canadians.

The Honourable Dr. Jane Philpott, P.C., M.P.
Minister of Health

Section I: Organizational Expenditure Overview

Organizational Profile

Appropriate Minister: The Honourable Dr. Jane Philpott, P.C, M.P.

Institutional Head: Simon Kennedy

Ministerial Portfolio: Health

Enabling Instrument(s): *Canada Health Act* [ii], *Canada Consumer Product Safety Act*[iii], *Canadian Environmental Protection Act*[iv], *Controlled Drugs and Substances Act*[v], *Food and Drugs Act*[vi], *Tobacco Act*[vii], *Hazardous Products Act*[viii], *Hazardous Materials Information Review Act*[ix], *Department of Health Act*[x], *Radiation Emitting Devices Act*[xi], *Pest Control Products Act*[xii].

List of Acts and Regulations [xiii]

Year of Incorporation / Commencement: 1913

Other: Canadian Food Inspection Agency joined the Health Portfolio in October 2013.

Organizational Context

Raison d'être

Health Canada regulates specific products and controlled substances, works with partners to support improved health outcomes for First Nations and Inuit, supports innovation and information sharing in Canada's health system to help Canadians maintain and improve their health, and contributes to strengthening Canada's record as a country with one of the healthiest populations in the world.

The Minister of Health is responsible for this organization.

Responsibilities

First, as a **regulator**, Health Canada is responsible for the regulatory regimes governing the safety of products including food, pharmaceuticals, medical devices, natural health products, consumer products, chemicals, radiation emitting devices, cosmetics and pesticides. It also regulates tobacco products and controlled substances and helps manage the health risks posed by environmental factors such as air, water, radiation and contaminants.

Health Canada is also a **service provider**. For First Nations and Inuit, Health Canada supports: basic primary care services in remote and isolated communities and public health programs including communicable disease control (outside the territories); home and community care; and, community-based health programs focusing on children and youth, mental health and addictions. Health Canada also provides a limited range of medically-necessary, health-related goods and services to eligible First Nations and recognized Inuit when not otherwise provided through other public programs or private insurance plans.

Health Canada is a **catalyst for innovation, a funder, and an information provider** in Canada's health system. It works closely with provincial and territorial governments to develop national approaches to health system issues, and promotes the pan-Canadian adoption of best practices. It administers the *Canada Health Act*, which embodies national principles for a universal and equitable, publicly-funded health care system. It provides policy support for the federal government's Canada Health Transfer to provinces and territories, and provides funding through grants and contributions (Gs&Cs) to various organizations to help meet overall health system objectives. Health Canada draws on leading-edge science and policy research to generate and share knowledge and information to support decision-making by Canadians, the development and implementation of regulations and standards, and health innovation.

Strategic Outcomes and Program Alignment Architecture

- 1 **Strategic Outcome:** A health system responsive to the needs of Canadians
  - 1.1 **Program:** Canadian Health System Policy
    - 1.1.1 **Sub-Program:** Health System Priorities
    - 1.1.2 **Sub-Program:** *Canada Health Act* Administration
  - 1.2 **Program:** Specialized Health Services
  - 1.3 **Program:** Official Language Minority Community Development
- 2 **Strategic Outcome:** Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians
  - 2.1 **Program:** Health Products
    - 2.1.1 **Sub-Program:** Pharmaceutical Drugs
    - 2.1.2 **Sub-Program:** Biologics & Radiopharmaceuticals
    - 2.1.3 **Sub-Program:** Medical Devices
    - 2.1.4 **Sub-Program:** Natural Health Products
  - 2.2 **Program:** Food Safety and Nutrition
    - 2.2.1 **Sub-Program:** Food Safety
    - 2.2.2 **Sub-Program:** Nutrition Policy and Promotion
  - 2.3 **Program:** Environmental Risks to Health
    - 2.3.1 **Sub-Program:** Climate Change and Health
    - 2.3.2 **Sub-Program:** Air Quality
    - 2.3.3 **Sub-Program:** Water Quality
    - 2.3.4 **Sub-Program:** Health Impacts of Chemicals
  - 2.4 **Program:** Consumer Product and Workplace Chemical Safety
    - 2.4.1 **Sub-Program:** Consumer Product Safety
    - 2.4.2 **Sub-Program:** Workplace Chemical Safety
  - 2.5 **Program:** Substance Use and Abuse
    - 2.5.1 **Sub-Program:** Tobacco
    - 2.5.2 **Sub-Program:** Controlled Substances
  - 2.6 **Program:** Radiation Protection
    - 2.6.1 **Sub-Program:** Environmental Radiation Monitoring and Protection
    - 2.6.2 **Sub-Program:** Radiation Emitting Devices
    - 2.6.3 **Sub-Program:** Dosimetry Services
  - 2.7 **Program:** Pesticides
- 3 **Strategic Outcome:** First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status
  - 3.1 **Program:** First Nations and Inuit Primary Health Care
    - 3.1.1 **Sub-Program:** First Nations and Inuit Health Promotion and Disease Prevention
      - 3.1.1.1 **Sub-Sub Program:** Healthy Child Development
      - 3.1.1.2 **Sub-Sub Program:** Mental Wellness
      - 3.1.1.3 **Sub-Sub Program:** Healthy Living
    - 3.1.2 **Sub-Program:** First Nations and Inuit Public Health Protection
      - 3.1.2.1 **Sub-Sub Program:** Communicable Disease Control and Management
      - 3.1.2.2 **Sub-Sub Program:** Environmental Public Health

- **3.1.3 Sub-Program:** First Nations and Inuit Primary Care
    - **3.1.3.1 Sub-Sub Program:** Clinical and Client Care
    - **3.1.3.2 Sub-Sub Program:** Home and Community Care
- **3.2 Program:** Supplementary Health Benefits for First Nations and Inuit
- **3.3 Program:** Health Infrastructure Support for First Nations and Inuit
    - **3.3.1 Sub-Program:** First Nations and Inuit Health System Capacity
        - **3.3.1.1 Sub-Sub Program:** Health Planning and Quality Management
        - **3.3.1.2 Sub-Sub Program:** Health Human Resources
        - **3.3.1.3 Sub-Sub Program:** Health Facilities
    - **3.3.2 Sub-Program:** First Nations and Inuit Health System Transformation
        - **3.3.2.1 Sub-Sub Program:** Systems Integration
        - **3.3.2.2 Sub-Sub Program:** e-Health Infostructure
    - **3.3.3 Sub-Program:** Tripartite Health Governance
- **Internal Services**
    - **Sub IS:** Governance and Management Support
        - **Sub-Sub IS:** Management and Oversight Services
        - **Sub-Sub IS:** Communications Services
        - **Sub-Sub IS:** Legal Services
    - **Sub IS:** Resource Management Services
        - **Sub-Sub IS:** Human Resources Management Services
        - **Sub-Sub IS:** Financial Management Services
        - **Sub-Sub IS:** Information Management Services
        - **Sub-Sub IS:** Information Technology Services
        - **Sub-Sub IS:** Other Administrative Services
    - **Sub IS:** Asset Management Services
        - **Sub-Sub IS:** Real Property Services
        - **Sub-Sub IS:** Materiel Services
        - **Sub-Sub IS:** Acquisition Services

Organizational Priorities

Organizational Priorities – Priority I

Priority	Type[1]	Strategic Outcome(s) [and/or] Programs
Priority I – Promote Health System Innovation	Ongoing	SO1 1.1 Canadian Health System Policy

Summary of Progress

The health care system is vital to addressing the health needs of Canadians. Although health care delivery is primarily under provincial jurisdiction, the federal government has an ongoing role in providing financial support for provincial and territorial health insurance plans, maintaining the core principles of the *Canada Health Act*, and supporting health care innovation and collaboration across jurisdictions. Health Canada can contribute to improving the quality and sustainability of health care as the system continues to evolve in a context of technological change, demographic shifts and fiscal pressures.

In 2014-15, Health Canada worked with provinces, territories and other health care partners on health system renewal, innovation and sustainability. The Department supported the Minister's engagement with the public and stakeholders on opportunities and challenges for Canada's health care system through speeches, roundtables, and outreach, and pursued discussions with the provinces and territories on health care innovation. On June 2014, the Advisory Panel on Healthcare Innovation was launched to take a focused look at creative ideas and approaches that exist in Canada and abroad, and to identify those that hold the greatest promise for Canada. The Panel consulted widely with governments, stakeholders and Canadians and will be completing its work in 2015.

Health Canada addressed priority health issues through collaboration with key pan-Canadian and other organizations under its Gs&Cs program. Highlights for 2014-15 include support to:

- Canada Health Infoway to advance electronic health systems, as important components of innovation in health care.
- Canadian Institute for Health Information to improve and report on national health information.
- Canadian Partnership against Cancer (CPAC) which has accelerated uptake of new knowledge and coordinated approaches to advance cancer control in Canada.
- Canadian Agency for Drugs and Technologies in Health (CADTH) to inform health care decision-makers about the effectiveness and efficiency of health technologies.
- Mental Health Commission of Canada and its stakeholders to promote changes to the mental health system innovation.
- Brain Canada Foundation in support of the Canada Brain Research Fund, an organization dedicated to advancing cutting-edge brain research.
- Canadian Patient Safety Institute to accelerate the pace of improvement in patient safety.

---

[1] Type is defined as follows: previously committed to—committed to in the first or second fiscal year prior to the subject year of the report; ongoing—committed to at least three fiscal years prior to the subject year of the report; and new—newly committed to in the reporting year of the Report on Plans and Priorities (RPP) or the Departmental Performance Report (DPR). If another type that is specific to the Department is introduced, an explanation of its meaning must be provided.

Health Canada coordinated its approach to health systems research, consulted across the Health Portfolio and academia, and strengthened in-house research capacity focused on health care system trends and impacts. Highlights for 2014-15 include:

- **Analyzing the emerging landscape of health care technology policy to identify potential areas for collaboration.**
- **Launching a series of projects, such as continuing care needs of an aging population, a policy research project on Social Health Insurance to contribute to the evidence base on the use of and affordability of home care and facility-based long-term care needs and costs in Canada, and a project to better understand the role of non-drug health technologies as a health system cost driver.**

Organizational Priorities – Priority II

Priority	Type	Strategic Outcome(s) [and/or] Programs
Priority II - Modernize Health Protection Legislation and Programs	Ongoing	SO2 2.1 Health Products 2.2 Food Safety and Nutrition 2.3 Environmental Risks to Health 2.4 Consumer Product and Workplace Chemical Safety 2.5 Substance Use and Abuse 2.6 Radiation Protection 2.7 Pesticides

Summary of Progress

Health Canada is responsible for a regulatory regime for products in the everyday lives of Canadians, including consumer products, food, pharmaceuticals, medical devices, natural health products, chemicals, radiation emitting devices, cosmetics, pesticides, tobacco products and controlled substances. As well, Health Canada helps to manage the risks posed by environmental factors, and the health implications of air quality, water quality, radiation, and environmental contaminants. Rapid technological change, the advent of products that blur traditional definitions, and incorporate innovative components, challenge Health Canada's ability to carry out its health and safety mandate. To address this challenge, Health Canada continues to modernize its regulatory programs.

Health Canada continued to implement a risk-based approach in the interest of consumer product safety in Canada. Highlights for 2014-15 include:

- Continued implementation of a risk-based Review of Regulations process through a five-year forward plan. The Review of Regulations process will ensure that Health Canada's suite of regulations remains effective in addressing risks posed by consumer products and is aligned with requirements under the Cabinet Directive on Regulatory Management.
- A work plan under the Cooperative Engagement Framework (Canada, United States (U.S.) and Mexico) has led to the establishment of four joint project teams with the three countries sharing technical and import information, as well as joint outreach campaigns on sports safety (June 2014), baby safety (September 2014) and industry requirements on strollers and toys (September 2014 and February 2015).
- All three countries also participated in an Organisation for Economic Co-operation and Development (OECD) international outreach campaign on button batteries and laundry detergent packets.
- Health Canada continued to strengthen its surveillance reports and ad hoc analytical activity requests to inform its outreach and compliance and enforcement activities.
- Using a risk-based approach, 13 Cyclical Enforcement Plan (CEP) projects were initiated for a number of product categories for which regulations exist under the Canada Consumer Product Safety Act. To date, these CEP projects have led to enforcement actions for non-compliant products, including 29 recalls. In total, approximately 250 recalls of non-compliant products were posted in 2014-15.
- In addition, Health Canada published the first Quarterly Consumer Product Safety Incident Report Summary and the first Consumer Product Enforcement Summary Report in March 2015.

The implementation of the Globally Harmonized System (GHS) of Classification and Labelling of Chemicals was advanced in 2014-15. On February 11, 2015, the Government of Canada published in the *Canada Gazette, Part II* the Hazardous Products Regulations[xiv], which in addition to the amendments made to the Hazardous Products Act under the Economic Action Plan 2014 Act, No.1[xv], modified the Workplace Hazardous Materials Information System (WHMIS) 1988 to incorporate the GHS for workplace chemicals. By adopting the GHS, Canada has achieved the Regulatory Cooperation Council (RCC) Joint Action Plan objective of reducing trade barriers and providing benefits for all stakeholders by reducing costs for suppliers, and ensuring employers and workers have access to consistent and coherent hazard information.

Health Canada continued to protect the health and safety of Canadians while reviewing and updating our regulatory frameworks based on sound science and research. Highlights for 2014-15 include:

- The *Protecting Canadians from Unsafe Drugs Act (Vanessa's Law)*[xvi] received Royal Assent in November. It amended the Food and Drugs Act to improve Health Canada's ability to collect post-market safety information, and take appropriate action when a serious risk to health is identified. It includes a new requirement for certain healthcare institutions to provide Health Canada with information on serious adverse drug reactions and medical device incidents.
- The Regulations Amending the *Food and Drug Regulations*[xvii] (Labelling, Packaging and Brand Names of Drugs for Human Use) were published which will improve the safe use of drugs by making drug labels and safety information easier to read and understand.
- The Department consulted on a new Consumer Health Products Framework aimed at providing a consistent approach to products of similar risk (natural health products, cosmetics, non-prescription drugs, disinfectants) whereby requirements are proportional to the benefit, harm, uncertainty profile of the products.

Health Canada contributed to the Government of Canada's efforts to reduce regulatory compliance burden and support co-operation with major trading partners. Highlights for 2014-15 include:

- Playing a leadership role in international collaborative activities in the review of generic drugs. These activities facilitated the efficient use of resources through information and work sharing with foreign regulatory counterparts.
- Working closely with the U.S., Australia, and Brazil on the Medical Device Single Audit Program, an effort to provide a single efficient audit of medical device manufacturers.
- Under the RCC initiative, Canada and the U.S. had one simultaneous veterinary drug approval, and nine drugs submitted for parallel review.

Health Canada provided citizens and stakeholders with the information they need to make informed decisions, and fostered an effective and transparent regulatory system for health protection as outlined in Health Canada's Regulatory Transparency and Openness Framework[xviii]. Highlights for 2014-15 include:

- Publishing 20 prescription and one non-prescription summary safety reviews in plain language for Canadians.
- The first plain language summary of a Novel Food Decision[xix] Document was published for the Arctic Apple[xx] approval.
- Developing the next phase of the Nutrition Facts Education campaign focusing on Serving Size and the Percent Daily Value.

Health Canada continued to deliver a pesticide regulatory program that is protective of human health and the environment, in a timely, transparent and accountable manner. The Department continued to meet regulatory, timeline and performance requirements of the *Pest Control Products Act*, including pesticide evaluation and re-evaluation, compliance and enforcement, and outreach and risk reduction strategies, in the face of evolving workload pressures and priorities.

Organizational Priorities – Priority III

Priority	Type	Strategic Outcome(s) [and/or] Programs
Priority III – Strengthen First Nations and Inuit Health Programming	Ongoing	SO3 3.1 First Nations and Inuit Primary Health Care 3.2 Supplementary Health Benefits for First Nations and Inuit 3.3 Health Infrastructure Support for First Nations and Inuit Internal Services (CFOB – IM/IT)

Summary of Progress

First Nations and Inuit continue to experience serious health challenges. Health Canada plays an important role in supporting the delivery of, and access to, health programs and services for First Nations and Inuit. Health Canada works with partners on innovative approaches to strengthening access to, and better integration of health services, as well as encourages greater control of health care delivery by First Nations and Inuit. Many departmental strategies evolved to correspond to the health needs of First Nations and Inuit. In addition, Health Canada also continues to work with partners to further the implementation of a Strategic Plan which is intended to provide a stronger sense of coherence and direction for Health Canada's activities in this area, and demonstrate how the Department collectively contributes to improving health outcomes for First Nations and Inuit.

Health Canada strengthened primary care and public health service models and strengthened access, quality and safety across the continuum of health services. Highlights for 2014-15 include:

- Enhancing the use of inter-professional teams and examining new models of care in remote and isolated communities.
- Modernizing Clinical Practice Guidelines for nurses in primary care.
- Launching a new marketing campaign as part of Health Canada's Nursing Recruitment and Retention Strategy.

Health Canada advanced collaborative effort with provinces/territories and First Nations and Inuit to ensure quality health services. Highlights for 2014-15 include:

- Continuing support for the implementation of the British Columbia Tripartite Framework Agreement on First Nation Health Governance.
- Investing in innovative approaches to integrate federal/provincial/territorial health services and improve access to quality health services for First Nations and Inuit.
- Working with the Assembly of First Nations (AFN) on an Engagement Protocol and with the Inuit Tapiriit Kanatami (ITK) on an Inuit Health Approach, to support a mutually acceptable standard of engagement for FNIHB policy and program initiatives.
- Finalizing a Joint Action Plan to enhance collaboration between First Nations, Health Canada, Alberta Health and Alberta Health Services, which was approved by the federal and Alberta Ministers of Health.

Health Canada improved the quality and availability of comprehensive mental health and addictions services, including defining service levels, standards and indicators. Key highlights for 2014-15 include:

- Finalizing the First Nations Mental Wellness Continuum Framework.
- Developing suicide prevention modules to support Mental Wellness Teams.
- Enhancing the Prescription Drug Abuse Strategy and client safety through the monitoring and surveillance of prescription drug utilization and prescribing patterns.

- Investing in training crisis teams in Manitoba and Saskatchewan as part of the Prescription Drug Abuse Strategy.

Health Canada emphasized collaborative/horizontal work with Aboriginal Affairs and Northern Development Canada, the Health Portfolio and other key partners. In 2014-15, Health Canada fully implemented AANDC's risk management tool (the General Assessment) using the Grants and Contributions Information Management System (GCIMS).

Health Canada ensured access to Non-Insured Health Benefits (NIHB) to First Nations and Inuit. Key highlights for 2014-15 included:

- Developing an interim five-year management plan for supplementary health benefits as part of ongoing efforts to increase efficiencies.
- Continuing work with the AFN and ITK on the Joint Review of the NIHB Program.

Health Canada improved the availability of and access to high quality data to better inform decision making and performance measurement and reporting. Key highlights for 2014-15 included:

- Developing a monitoring and performance framework for tuberculosis programs as part of the early implementation of Health Canada's Strategy Against Tuberculosis for First Nations On-Reserve.
- Completing regional assessments to inform the development of a surveillance and information framework relevant for communities and aligned with First Nations/ Inuit/ provincial/territorial surveillance and information strategies.
- Training approximately one thousand workers in the correct use of enhanced personal protective equipment in response to the Ebola crisis.

Organizational Priorities – Priority IV

Priority	Type	Strategic Outcome(s) [and/or] Programs
Priority IV – Continue to build an efficient, interconnected and adaptable organization with improved processes, structures and systems	Ongoing	Internal Services

Summary of Progress
The success of Health Canada depends on having processes, structures and systems that support its programs to excel in meeting their objectives. These foundations are critical to assist the Department to adapt to changing pressures, devise innovative approaches to problems, work collaboratively to address common issues, and provide efficient and cost-effective services to internal and external clients. Cutting edge public communications and engagement services and systems are vital to promote public health and provide relevant, accessible public health information. In 2014-15 the Department is focused on improving business approaches and streamlining services independently and in partnership with Government of Canada organizations. Through the Shared Services Partnership advances were made on government-wide modernization and transformation initiatives such as e-mail transformation initiative, the Windows 7 project completion, the IM maturity initiative, cost effective telephone services and Workplace 2.0. Health Canada also conducted successful testing of all systems related to a multi-departmental initiative (led by the Canada Border Services Agency) to implement a single window through which importers can electronically submit information necessary to comply with government import regulations. Health Canada undertook several initiatives that served to improve internal processes and provide better services to Canadians and clients. Highlights for 2014-15 include: • Successfully transitioning Public Health Agency of Canada (PHAC) to the new GCIMS in partnership with Aboriginal Affairs and Northern Development Canada (AANDC). All 2014-15 payments were processed using GCIMS payment module. • Implementing the on-going risk-based monitoring strategy for Internal Controls over Financial Reporting for Health Canada's and PHAC's common key controls related to financial statements. • Initiating the Planning for Enterprise Performance (PEP) project which will result in high degree of alignment between financial and non-financial planning and reporting activities and priorities in Health Canada and partner departments. • Successfully rolled out to both Health Canada and PHAC, in support of the Shared Services Partnership, the new Shared Travel Services products and tools such as Government Travel Card, Online Booking Tool, Travel Expense Management Tool and Travel Agency Services.

Risk Analysis

The following table describes the key risks identified by Health Canada as having the highest likelihood and impact on program delivery in 2014-15 and provides examples of how the Department responded to those risks. The risks and risk responses identified below were also listed in the 2014-15 RPP, and served to inform prioritization, decision-making, and resource allocation, with a focus on strategic outcomes and long-term priorities.

Key Risks

Risk	Risk Response Strategy	Link to Program Alignment Architecture
1. Risks exist with the ability to reform legislative and regulatory systems: a. Need to leverage international cooperation and alignment. b. Meeting demand for openness and transparency.	Health Canada leveraged and exchanged information with foreign regulators by means of quarterly planned multilateral Cluster Meetings. In addition, ad-hoc bilateral teleconferences with other regulators were held to discuss common submissions. When appropriate, the program used foreign review reports as a further source of information. In order to build on international efforts to assess and manage chemicals, assessments of existing substances in Canada continued to take into consideration regulatory information and activities in other countries, as appropriate. Health Canada continued to work with key regulatory partners at the World Health Organization to share best practices on product regulation for tobacco products. Health Canada also worked collaboratively with international partners to effectively harmonize regulatory processes by participating as: • Member and Chair of the International Coalition of Medicines Regulatory Authorities. • Member of harmonization initiatives such as International Conference on Harmonisation. • On-going exchange of regulatory information. Health Canada launched the Regulatory Transparency and Openness Framework in April 2014 in order to improve access to timely, useful and relevant health and safety information available to Canadians. The first year of the Framework produced significant achievements, including: the launch of the Drug and Health Product Register, a new resource for Canadians looking for information on prescription drugs; and consultation with Canadians to determine how to improve nutritional information on food labels.	• PA: 2.1, 2.2, 2.3, 2.4, 2.5, 2.7 • OP: II, IV

Risk	Risk Response Strategy	Link to Program Alignment Architecture
2. Risks exist with First Nations and Inuit Health System Innovation: a. Differing regional circumstances and contextual environments. b. Varying capacity of partners. c. Alignment between Health Canada and local health needs.	In 2014-15, Health Canada supported over 300 communities to design, deliver and manage health programs and services through Flexible or Block funding arrangements. 518 communities across all provinces and territories were involved in Health Services Integration Fund projects that supported innovative approaches to integrate federal and provincial health services. In addition, the department supported the development of the First Nations Mental Wellness Continuum Framework in partnership with key stakeholders, which provides guidance on adapting and realigning programs and services to be more flexible and responsive to community needs.	• PA: 3.1, 3.2, 3.3 • OP: III
3. Risks exist with the ability to deliver high quality health services to First Nations and Inuit: a. Sustainability of primary care. b. Variable capacity of partners. c. Lack of program data.	Health Canada continued to enhance new models of care by reorienting service delivery toward inter-professional teams and establishing a Relief Nursing Coordination Unit to introduce standardization and manage nursing relief service contracts in three regions. In addition, a 10-year Home and Community Care Program Plan was finalized to assist program staff to anticipate and respond to evolving health needs and trends associated with home care for First Nation and Inuit clients. Health Canada undertook monitoring and surveillance of prescription drug utilization and prescribing patterns as part of its strategy to address prescription drug abuse. Additionally, Health Canada continued to work with AANDC and First Nations communities on data linkages between the Indian Registry System and provincial data sets.	• PA: 3.1, 3.2, 3.3 • OP: III
4. Risks exist with implementing innovations in Grants & Contributions (Gs&Cs) delivery to Canadians: a. Pressure to reduce administrative burden on clients. b. Meeting demand for openness and transparency. c. Transitioning to new GCIMS.	The Department successfully adopted GCIMS in a phased approach to ensure that the support capacity can meet program requirements. Health Canada and AANDC continue to collaborate on the new functions in GCIMS such as Debt Management and Multi-Year functions. These new functions will benefit both AANDC and Health Canada portfolio users. Health Canada also adopted a general assessment module in GCIMS along with the common process and e-learning training material and piloted an automated performance measurement system for Gs&Cs to support improved recipient reporting and program management.	• PA: 1.1, IS.1.1 • OP: I, IV

Risk Narrative

Effective risk management practices equipped Health Canada to respond proactively to change and uncertainty by using risk-based approaches and information to enable more effective decision-making throughout the organization.

Health Canada faced an array of pressures both internal and external that had the potential to impact the Department as it delivered its programs and services. Because of its broad mandate, the Department is exposed to risks that are largely beyond its control, such as the aging population, unforeseen health crises, new innovative products, substances, food and emerging product categories, scientific and technological change, and cyber security.

Health Canada managed its key risks in a variety of ways. For example, in order to ensure regulatory and policy consistency with international partners, Health Canada continued to coordinate with its international counterparts and share best practices to effectively align regulatory processes. Additionally, Health Canada continued to take steps to effectively manage risks around greater alignment and integration of First Nations and Inuit health care with provincial health systems and local health delivery organizations. The Department successfully adopted the GCIMS in a phased approach to ensure that the support capacity can meet program requirements.

Finally, Canadians increasingly expected to communicate with Health Canada and receive up-to-date health information through the Internet and other social media. Health Canada continued to provide timely and evidence-based health and safety information to meet public, client, and stakeholder expectations.

Actual Expenditures

Budgetary Financial Resources (dollars)

2014-15 (Main Estimates)	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	Difference (actual minus planned)
3,657,312,088	3,658,912,088	3,909,808,102	3,814,473,966	155,561,878

Note: The increase of $250.9 million between planned spending and total authorities is mainly due to the receipt of in-year funding through Supplementary Estimates as well as from the Department's operating and capital budget carry forwards that were allocated to fund strategic investments as per Health Canada's recently approved Investment Plan. Total authorities were also supplemented by statutory items, the reimbursement of paylist expenditures, and payments required by collective agreements.

The $95.3 million difference between total authorities and actual spending is mainly related to: surpluses in transfer payments; NIHB funding held in a frozen reserve by central agencies; surplus in the Indian Residential Schools Resolution Health Support Program; as well as a portion of the operating budget that was carried forward to support strategic investments in 2015-16.

Human Resources (Full-time Equivalents [FTEs])

2014-15 Planned[2]	2014-15 Actual	2014-15 Difference (actual minus planned)
9,081	8,756	-325

Note: The variance between actual and planned FTEs is mainly the result of: management's efforts to stabilize and control future salary requirements through personnel departures and delays in staffing vacant positions.

---

[2] While the total planned FTE amount is accurate, a realignment of planned FTEs at a lower level is needed to reflect current business requirements.

Budgetary Performance Summary for Strategic Outcomes and Programs (dollars)

Strategic Outcomes and Programs and Internal Services	2014-15 Main Estimates	2014-15 Planned Spending	2015-16 Planned Spending	2016-17 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2013-14 Actual Spending (authorities used)	2012-13 Actual Spending (authorities used)
Strategic Outcome 1: A health system responsive to the needs of Canadians								
1.1 Canadian Health System Policy	242,633,254	244,186,030	260,390,118	279,235,095	359,916,645	334,273,289	353,877,280	405,697,982
1.2 Specialized Health Services	18,728,166	18,728,166	19,133,053	18,594,271	15,315,788	13,650,940	16,475,781	19,926,803
1.3 Official Language Minority Community Development	37,527,825	37,527,825	37,528,856	38,090,836	37,412,211	36,653,712	25,830,789	39,011,188
Sub-Total	**298,889,245**	**300,442,021**	**317,052,027**	**335,920,202**	**412,644,644**	**384,577,941**	**396,183,850**	**464,635,973**
Strategic Outcome 2: Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians								
2.1 Health Products	152,060,884	152,060,884	148,110,784	144,368,697	167,240,719	166,617,222	179,564,797	164,654,898
2.2 Food Safety and Nutrition	59,175,139	59,175,139	67,838,730	63,411,776	66,393,020	66,365,087	71,238,491	69,655,161
2.3 Environmental Risks to Health	102,849,859	102,849,859	100,282,109	32,895,947	107,392,104	97,967,114	101,141,190	103,655,546
2.4 Consumer Product and Workplace Chemical Safety	37,725,014	37,725,014	37,689,337	32,920,119	37,697,458	34,325,605	35,535,627	28,148,044
2.5 Substance Use and Abuse	82,748,939	82,748,939	86,731,215	87,710,622	74,460,754	69,339,368	88,591,578	115,533,278
2.6 Radiation Protection	20,522,668	20,522,668	20,282,587	13,097,382	21,345,176	20,709,033	21,420,658	15,303,974
2.7 Pesticides	40,651,125	40,651,125	40,190,336	35,248,559	45,426,812	44,319,169	46,299,835	42,148,137
Sub-Total	**495,733,628**	**495,733,628**	**501,125,098**	**409,653,102**	**519,956,043**	**499,642,598**	**543,792,176**	**539,099,038**

Strategic Outcome 3: First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status								
3.1 First Nations and Inuit Primary Health Care	853,702,552	853,702,552	809,838,696	746,688,679	884,879,027	870,774,016	927,125,272	945,580,413
3.2 Supplementary Health Benefits for First Nations and Inuit	1,133,324,859	1,133,324,859	1,128,474,836	1,077,480,363	1,104,008,776	1,075,694,038	1,071,034,484	1,140,213,493
3.3 Health Infrastructure Support for First Nations and Inuit	604,177,779	604,177,779	635,463,846	664,358,695	640,557,440	640,190,204	525,066,806	356,715,000
Sub-Total	**2,591,205,190**	**2,591,205,190**	**2,573,777,378**	**2,488,527,737**	**2,629,445,243**	**2,586,658,258**	**2,523,226,562**	**2,442,508,906**
Internal Service Sub-Total	**271,484,025**	**271,531,249**	**266,815,846**	**252,973,346**	**347,762,172**	**343,595,169**	**364,976,909**	**374,914,169**
Total	**3,657,312,088**	**3,658,912,088**	**3,658,770,349**	**3,487,074,387**	**3,909,808,102**	**3,814,473,966**	**3,828,179,497**	**3,821,158,086**

Note: The decrease in planned spending in 2016-17 under Strategic Outcome 2 is mainly due to the sunsetting of time-limited spending authorities relating to the following initiatives: Chemicals Management Plan, Clean Air Regulatory Agenda, Adaptation to Climate Change under Canada's Clean Air Agenda, and Funding relating to the assessment, management, and remediation of federal contaminated sites.

The Government of Canada reassesses priorities, as required, and programs that are set to sunset will be considered for renewal and may in fact be renewed.

At the outset of the 2014-15 fiscal year, Health Canada's planned spending was $3,658.9 million. Primarily through Main Estimates and Supplementary Estimates, Health Canada was allocated total authorities of $3,909.8 million. The Department's actual spending was $3,814.5 million.

The $1.6 million increase from 2014-15 Main Estimates to planned spending is due to funding for the renewal of the Genomics Research and Development Initiative.

The $250.9 million increase from planned spending to total authorities in 2014-15 is mainly due to funding received for: the Territorial Health Investment Fund; the renewal of the First Nations Water and Wastewater Action Plan; government advertising programs; statutory items; the departmental operating and capital budget carry forwards; reimbursement of paylist expenditures; and collective agreements.

The $95.3 million difference between total authorities and actual spending in 2014-15 is mainly the result of surpluses in transfer payments including the Canada Brain Research Fund, Anti-Drug Strategy Initiatives (ADSI), and Health Care Policy Program; NIHB funding held in a frozen reserve by central agencies; surplus in the Indian Residential Schools Resolution Health Support Program; as well as a portion of the operating budget that was carried forward to support strategic investments in 2015-16.

Alignment of Spending With the Whole-of-Government Framework

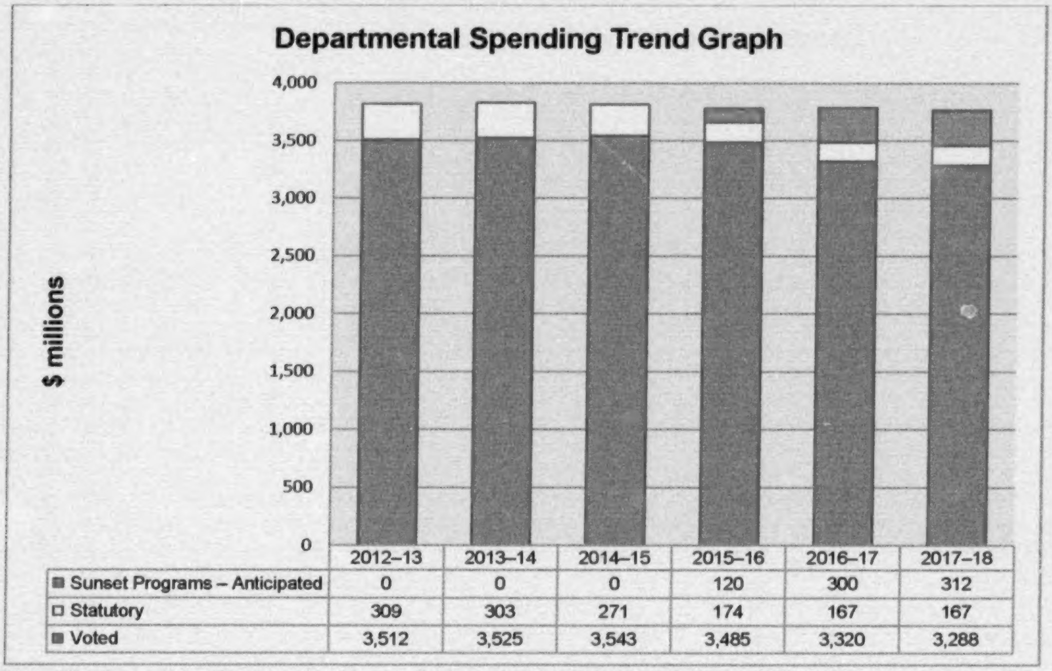
Alignment of 2014-15 Actual Spending With the Whole-of-Government-Framework[xxi] (dollars)

Strategic Outcome	Program	Spending Area	Government of Canada Outcome	2014-15 Actual Spending
SO 1 A health system responsive to the needs of Canadians	1.1 Canadian Health System Policy	Social Affairs	Healthy Canadians	334,273,289
	1.2 Specialized Health Services	Social Affairs	Healthy Canadians	13,650,940
	1.3 Official Language Minority Community Development	Social Affairs	Healthy Canadians	36,653,712
SO 2 Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians	2.1 Health Products	Social Affairs	Healthy Canadians	166,617,222
	2.2 Food Safety and Nutrition	Social Affairs	Healthy Canadians	66,365,087
	2.3 Environmental Risks to Health	Social Affairs	Healthy Canadians	97,967,114
	2.4 Consumer Product and Workplace Chemical Safety	Social Affairs	Healthy Canadians	34,325,605
	2.5 Substance Use and Abuse	Social Affairs	Healthy Canadians	69,339,368
	2.6 Radiation Protection	Social Affairs	Healthy Canadians	20,709,033
	2.7 Pesticides	Social Affairs	Healthy Canadians	44,319,169
SO 3 First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status	3.1 First Nations and Inuit Primary Health Care	Social Affairs	Healthy Canadians	870,774,016
	3.2 Supplementary Health Benefits for First Nations and Inuit	Social Affairs	Healthy Canadians	1,075,694,038
	3.3 Health Infrastructure Support for First Nations and Inuit	Social Affairs	Healthy Canadians	640,190,204

Total Spending by Spending Area (dollars)

Spending Area	Total Planned Spending	Total Actual Spending
Economic Affairs		
Social Affairs	3,387,380,839	3,470,878,797
International Affairs		
Government Affairs		

Departmental Spending Trend


Departmental Spending Trend Graph

	2012–13	2013–14	2014–15	2015–16	2016–17	2017–18
▨ Sunset Programs – Anticipated	0	0	0	120	300	312
☐ Statutory	309	303	271	174	167	167
▨ Voted	3,512	3,525	3,543	3,485	3,320	3,288

Note: The figure above illustrates Health Canada's spending trend from 2012-13 to 2017-18.

The additions to planned voted and statutory spending reflect estimated renewals of certain sunsetting programs, which are under further review and consideration by the government. The reduction of planned spending from previous years is mainly due to continued savings from the implementation of the 2012 Budget, and the exclusion of carry forward adjustments, paylist reimbursement, collective agreement funding and certain statutory funding.

In 2014-15, Health Canada spent $3,814 million to meet expected program activity results and contribute to the achievement of departmental strategic outcomes.

For the 2012-13 to 2014-15 period, the total of voted and statutory spending correspond to total authorities used as shown in the Public Accounts of Canada.

For the 2015-16 to 2017-18 period, the total of voted and statutory spending correspond to planned spending which excludes in-year funding from Supplementary Estimates, carry forward adjustments, and certain statutory funding.

Expenditures by Vote

For information on Health Canada's organizational voted and statutory expenditures, consult the *Public Accounts of Canada 2015*[xxii] which is available on the Public Works and Government Services Canada website.

Section II: Analysis of Programs by Strategic Outcome

Strategic Outcome 1: A health system responsive to the needs of Canadians

Program 1.1: *Canadian Health System Policy*

Description

The Canadian Health System Policy program provides strategic policy advice, research, and analysis to support decision-making on health care system issues, as well as program support to provinces and territories, partners, and stakeholders on health care system priorities.

Mindful of equity, sustainability, and affordability Health Canada collaborates and targets its efforts in order to support improvements to the health care system such as improved access, quality, and integration of health care services.

Through the management of grants and contributions (Gs&Cs) agreements with key pan-Canadian health partners, the Canadian Health System Policy program contributes to priority health issues requiring national leadership and strong partnership.

The program objective is to support innovative health care policy and programs to help Canadians maintain and improve their health.

Budgetary Financial Resources (dollars)

2014-15 Main Estimates	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
242,633,254	244,186,030	359,916,645	334,273,289	90,087,259

Note: The variance of $1.6 million between Main Estimates and planned spending is due to funding for the renewal of the Genomics Research & Development Initiative.

The variance of $90.1 million between actual and planned spending is mainly due to statutory grant funding for electronic health information communication technologies, and contribution funding for the Territorial Health Investment Fund. This is partly offset by surpluses in the Canada Brain Research Fund, Health Council of Canada, and the Health Care Policy Program, as well as internal reallocations of funding between programs.

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
238	182	-56

Note: The variance between actual and planned FTEs is mainly the result of: management's efforts to stabilize and control future salary requirements through personnel departures and delays in staffing vacant positions.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Acts as a catalyst to address current and emerging health issues and priorities.	# of actions taken (e.g. Gs&Cs signed) to respond to current and emergent issues.	6 by March 31, 2015	6

Performance Analysis and Lessons Learned

Health Canada successfully advanced health care innovation as an area of policy priority, building interest and generating connections in the health care community and other sectors. Health Canada managed new and existing funding agreements that advanced priority health issues, including the following funding:

- $8.1 million over two years to the Ontario Ministry of Health and Long-Term Care for three initiatives supporting internationally educated health professionals and their potential employers.
- $3 million over three years to the Canadian Hospice Palliative Care Association for "The Way Forward" initiative which supported the development of a framework to allow palliative care to be delivered in a broader range of settings and by a variety of providers, which includes best practices, priorities for action and a roadmap for implementation.
- $6.5 million over three years for McMaster University in support of innovative approaches to primary health care through the use of teams, system navigation and Electronic Medical Records (EMR), to ultimately improve health care performance.
- $3 million for a Pallium Foundation of Canada initiative to equip more front-line health care providers with the skills and knowledge needed to provide quality palliative care in a range of settings for people with life-threatening conditions.
- $1.6 million for the Canadian Medication and Incident Reporting and Prevention System project, through the Health Care Policy Contribution Program, to generate evidence on medication incidents in order to improve patient safety.
- $5 million for the first year of a five-year agreement for the Canadian Blood Services (CBS) to work on blood research and development.
- $14.3 million for the Mental Health Commission of Canada in support of public education and awareness on mental health issues, dissemination of mental health data and research, and policy development and collaboration with provinces and territories and mental health stakeholders to improve mental health outcomes of in Canadians. In addition, $2.5 million was provided to the Mood Disorders Society of Canada to develop

initiatives to improve the treatment of depression, post-traumatic stress disorder, and other mood disorders.

- $5.4 million to support the Canadian Brain Research Foundation, which is managed by Brain Canada, an organization dedicated to advancing cutting-edge brain research.
- $3.43 million to CBS in the final year of the Organ and Tissue Donation and Transplantation program agreement.

In parallel to funding agreements, Health Canada continued working to modernize processes for the management of Gs&Cs. For example, this included the implementation of a pilot for an automated system for data collection analysis and reporting on performance.

The Department also continued to monitor and analyse pharmaceutical trends and worked with Canadian and international partners to raise the awareness of the impact of high cost drugs on drug expenditure and drug coverage and to explore policy options to manage this pressure more effectively.

Sub-Program 1.1.1: *Health System Priorities*

Description

Through the Health System Priorities program, Health Canada works closely with provincial and territorial governments, domestic and international organizations, health care providers, and other stakeholders to develop and implement innovative approaches, improve accountability, and responses to meet the health priorities and health services needs of Canadians. Key activities include increasing the supply of health professionals, timely access to quality health care services, and accelerating the development and implementation of electronic health technologies.

The program also manages Gs&Cs agreements on a number of health care priorities, such as Canada Health Infoway (CHI), the Canadian Institute for Health Information (CIHI), Mental Health Commission of Canada, and the Canadian Partnership Against Cancer (CPAC), to support health care services for all Canadians.

The program objective is to ensure that Canadians have access to quality and cost-effective health care services.

This program uses funding from the following transfer payments: Brain Canada Foundation, Canadian Agency for Drugs and Technologies in Health (CADTH), CIHI, CPAC, Canadian Patient Safety Institute (CPSI), Health Council of Canada, Health Care Policy Contribution Program, Mental Health Commission of Canada, Mood Disorders Society of Canada, CHI, and Canadian Foundation for Health Care Improvement (CFHI).

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
242,297,543	332,480,234	90,182,691

Note: The variance between actual and planned spending is mainly due to the inclusion of statutory grant funding for electronic health information communication technologies.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
219	167	-52

Note: The variance between actual and planned FTEs is mainly the result of: management's efforts to stabilize and control future salary requirements through personnel departures and delays in staffing vacant positions.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Improved and maintained strategic partnerships with key national provincial, territorial and regional partners (e.g., through funding such as Grants & Contributions) to advance health system priorities.	# and type of new/maintained and/or improved collaborative working arrangements and/or agreements between Government of Canada, provincial and territorial, and stakeholders to advance health system renewal.	10 by March 31, 2015	10

Performance Analysis and Lessons Learned

In 2014-15, Health Canada continued to provide support and work collaboratively with pan-Canadian health organizations to strengthen healthcare innovation. In particular, the Department:

- Collaborated with CHI to advance electronic health systems, as important components of innovation in healthcare. As of March 2015, 91% of Canadians have components of an EMR available to their health professionals, and close to 20,000 physicians have enrolled in jurisdictional programs for physician office systems. Additional information is available in Infoway's annual report.
- Continued to fund the CPAC, in the amount of $241 million over five-years ending in 2017. CPAC has advanced cancer control in Canada, yielding health system improvements including enhanced development and implementation of knowledge, best practices and guidelines.
- Amended the Health Canada – CIHI agreement with a one year extension to permit them to conduct a strategic planning session and to provide funds for increased monitoring and surveillance of prescription drug abuse.

- Conducted an Evaluation of the Health Information Initiative[xxiii]. Results showed that the Program was successful in increasing awareness and understanding.
- Provided funding and support to the CPSI to advance efforts to improve patient safety and quality in Canada.
- Maintained collaborative working arrangement with the Canadian Foundation for Healthcare Improvement (CFHI), including discussions for renewed federal funding.
- Expanded the mandate of the Common Drug Review (CDR) to cover biologic and orphan drugs and added the pan Canadian Oncology Review (pCODR) program to the CADTH's suite of programs. As a result the review and recommendation approaches for CDR and pCODR can be more effectively aligned and this should over time lead to more consistent formulary listing decisions across participating federal, provincial and territorial jurisdictions.

Sub-Program 1.1.2: *Canada Health Act Administration*

Description

The administration of the *Canada Health Act* involves monitoring a broad range of sources to assess the compliance of provincial and territorial health insurance plans with the criteria and conditions of the Act, working in partnership with provincial and territorial governments to investigate and resolve concerns which may arise, providing policy advice and informing the Minister of possible non-compliance with the Act, recommending appropriate action when required, and reporting to Parliament on the administration of the Act.

The program objective is to facilitate reasonable access to insured health care services without financial or other barriers.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
1,888,487	1,793,055	-95,432

Note: The variance between actual and planned spending is mainly due to paylist requirements[3].

---

[3] Paylist requirements include funds for parental benefits, severance pay and vacation credits payable upon termination of employment with the Public Service.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
19	15	-4

Note: The variance between actual and planned FTEs is mainly the result of: management's efforts to stabilize and control future salary requirements through personnel departures and delays in staffing vacant positions.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Provincial and territorial compliance with the requirements of the *Canada Health Act*.	% of *Canada Health Act* compliance issues concluded.	100 by March 31, 2015	67

Performance Analysis and Lessons Learned

In line with the Canadian Health System program objective, the aim of the *Canada Health Act* is to facilitate reasonable access to medically necessary hospital and physician services for all Canadians. The Act sets out the criteria and conditions provinces and territories must comply with to receive the full amount of the Canada Health Transfer they are entitled to during a given fiscal year.

Canada Health Act compliance issues that are considered for the purpose of this reporting exercise are those that were raised or resolved during the reporting period, as well as ongoing issues that resulted in the application of deductions to Canada Health Transfer payments to a province or territory. Issues are considered concluded once a province or territory has made a commitment to take definitive action to eliminate the circumstances that led to a compliance issue.

For the most part, *Canada Health Act* compliance issues are related to inappropriate patient charges by providers of insured health services (i.e., hospitals, clinics and physicians). There are albeit fewer instances where one or more *Canada Health Act* criteria (e.g., comprehensiveness, portability and accessibility) are involved.

The responsibility for ensuring that providers of insured services operate in compliance with the requirements of the Act rests with the provinces and territories. Health Canada does not have jurisdiction over providers of insured services, nor does it have formal investigative powers to collect information on various practices that may be inconsistent with the requirements of the Act. As a result, federal officials must work collaboratively with their provincial and territorial counterparts to investigate and resolve compliance issues. Compliance investigations are complex and often sensitive in terms of privacy. They often require extensive research and negotiations between government officials and providers of services before they can be concluded.

During 2014-15, six compliance issues were addressed, with four being concluded (67%). Health Canada is still in consultation with the respective provincial health ministries on the two outstanding issues.

Program 1.2: *Specialized Health Services*

Description

The Specialized Health Services program supports the Government of Canada's obligation to protect the health and safety of its employees and the health of visiting dignitaries.

Health Canada delivers counselling, organizational development and critical incident support services to federal government departments through a network of contracted mental health professionals and also provides immediate response to employees following traumatic incidents in the workplace.

Health Canada delivers medical services to federal public servants who may be exposed to specific health risks due to their type of work. By providing occupational and psycho-social health services to federal public servants, Health Canada pro-actively contributes to reducing the number of work days lost to illness across the federal government.

Health Canada also arranges for the provision of health services for Internationally Protected Persons (IPP) who have come to Canada for international events, such as meetings or official visits by government leaders or the Royal Family. An IPP is a representative of a State, usually Heads of State and/or Government, members of the Royal Family, or officials of an international organisation of an intergovernmental character.

The program objective is to ensure continuity of services and the occupational health of federal public servants who can deliver results to Canadians in all circumstances and to arrange health services for IPPs.

Budgetary Financial Resources (dollars)

2014-15 Main Estimates	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
18,728,166	18,728,166	15,315,788	13,650,940	-5,077,226

Note: The variance of $5.1 million between actual and planned spending is mainly due to statutory expenditures reported under another program within this strategic outcome, and lower than expected demand for psychologist and mental health service providers for the Employee Assistance Program and related services.

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
263	181	-82

Note: The variance in FTE utilization is mainly due to a refocused service delivery mandate and restructuring of operations. Reductions in FTEs were achieved through attrition and voluntary departures. The reduced FTEs resulted in greater efficiencies from the realignment of the Public Service Occupational Health Program.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Federal employees are able to manage their psycho-social issues during and immediately following, stressful or traumatic events.	% of psycho-social cases that are closed within 8 Employee Assistance Program sessions.	70 by March 31, 2015	95
Reduced absenteeism in the workplace for employees who access employee assistance services (EAS).	% reduction in absenteeism in the 30 days that follow an employee's last Employee Assistance Program session versus the 30 days prior.	25 by March 31, 2015	43.8
IPP have access to health services and medical treatment they might require when they are in Canada for regular visits or to participate in major international events.	% of cases examined in which support provided was rated as acceptable or strong (client assessment).	100 by March 31, 2015	100

Performance Analysis and Lessons Learned

Health Canada continued to provide occupational health and psycho-social support to public servants to ensure continuity of service to Canadians. The program successfully met its operational targets in Employee Assistance Services (EAS), the Public Service Occupational Health Program (PSOHP) and the IPP health services program.

In 2014-15, Health Canada negotiated additional Interdepartmental Letters of Agreements (EAS service contracts) with the Canada Council for the Arts, Financial Consumer Agency of Canada and the Office of the Communications Security Establishment Commissioner. In addition, in response to a request from Veterans Affairs Canada, EAS services were enhanced to extend the Employee Assistance Program and bereavement services for their populations. Also of note, EAS' trauma response services were provided to federal public servants and their families as a result of the New Brunswick RCMP and Ottawa war memorial shooting incidents.

Health Canada experienced an increase in revenue for EAS from $12.2M in 2013-14 to approximately $14 million in 2014-15. This increase is due in large part to increased interest in EAS services, including the Specialized Organizational Services. As a result of recommendations from the EAS evaluation[xxiv], a new case management system is being developed to improve data collection and analysis. In addition, EAS continued to monitor and provide input regarding the program's role within the Treasury Board Secretariat (TBS) led Workplace Wellness and Productivity Strategy.

While requests to PSOHP for communicable disease related services decreased, the number of health evaluations completed meets the completion rate for fiscal year 2013-14. In addition, respondents to the PSOHP Client Feedback Survey indicated a 91% satisfaction rate with the quality of services received.

Health Canada developed 100 health contingency plans for IPPs and their families visiting Canada in 2014-15. A new service delivery model was developed for the provision of food surveillance services, resulting in access to more than 30 Environmental Officers across the country. The new model will be fully implemented in 2015-16.

Health Canada continued to partner with the TBS and other departments to contribute to the Government of Canada's Workplace Wellness and Productivity Strategy. Through its active participation, Health Canada supported the continuous development and improvement of new and existing services and programs for the purpose of maximizing wellness and productivity amongst federal employees.

Program 1.3: *Official Language Minority Community Development*

Description

The Official Language Minority Community Development program involves the administration of Health Canada's responsibilities under Section 41 of the *Official Languages Act*[xxv]. This Act commits the federal government to enhancing the vitality of Official Language Minority Communities (OLMC) and fostering the full recognition and use of English and French in Canadian society.

This program includes: consulting with Canada's OLMC on a regular basis; supporting and enabling the delivery of contribution programs and services for OLMC; reporting to Parliament and Canadians on Health Canada's achievements under Section 41; and, coordinating Health Canada's activities and awareness in engaging and responding to the health needs of OLMC.

The program objectives are to improve access to health services in the minority official language communities and to increase the use of both official languages in the provision of health care services.

This program uses funding from the following transfer payment: Official Languages Health Contribution Program (OLHCP).

Budgetary Financial Resources (dollars)

2014-15 Main Estimates	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
37,527,825	37,527,825	37,412,211	36,653,712	-874,113

Note: The variance of $0.9 million between actual and planned spending is mainly due to revised implementation timelines for contribution agreements.

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
10	8	-2

Note: The variance between actual and planned FTEs is mainly the result of: management's efforts to stabilize and control future salary requirements through personnel departures and delays in staffing vacant positions.

Performance Measurement

Expected Results	Performance Indicators	Targets	Actual Results
OLMC have access to health care services in the official language of their choice.	# of health professionals who have successfully completed training programs (funded by Health Canada).	1,900* by March 31, 2015	1,020**
	% of program trained health professionals who are retained.	86 by March 31, 2015	87

* Targets were set according to the training capacities of the postsecondary institutions in receipt of funding and based upon their declared targets in their funding proposals.

** Late authority received by one institution to enter into an agreement with Health Canada resulted in training targets for 2014-15 not being met.

Performance Analysis and Lessons Learned

Under the OLHCP, 12 contribution agreements totalling $72.7 million were signed with the following postsecondary institutions for 2014-15 to 2017-18 to train French-speaking health professionals outside Quebec: Association des collèges et universités de la francophonie canadienne; Société éducative de l'Île-du-Prince-Édouard; Université Sainte-Anne; Collège Communautaire du Nouveau-Brunswick; Centre de formation médicale du Nouveau-Brunswick; Université de Moncton; La Cité collégiale; Université Laurentienne de Sudbury; Université d'Ottawa; Collège Boréal d'arts appliqués et de technologie; Université Saint-Boniface; University of Alberta (Campus Saint-Jean).

An agreement for $16.3 million was signed with McGill University to improve the availability of health professionals for Quebec's English-speaking population.

Agreements totalling $2.7 million were signed, for 2014-15 to 2016-17 to support innovative projects to increase access to healthcare services for Francophones outside of Quebec and Anglophones living in Quebec. The recipients were:Association of Faculties of Medicine of Canada; Health Prince Edward Island; Centre communautaire Sainte-Anne; AMI-Québec; Ottawa Regional Cancer Foundation; La Fédération des parents du Manitoba; Association canadienne française de l'Alberta régionale de Calgary.

With Health Canada's funding support:

- One hundred and fifty (150) health professionals from Quebec completed language training.
- Eight hundred and seventy (870) French-speaking students graduated in health disciplines in 98 postsecondary programs in 11 colleges and universities located outside of Quebec.
- A 2015 evaluation was completed for McGill University on incentive bursaries provided to Quebec English-speaking health system graduates (2011-14), encouraging them to practice in regions outside of Montreal. Findings showed that 88% were practicing in these regions, after completing the stipulated one year period.
- Thirty-eight (38) community-based networking partnerships maintained across Canada, and in 14 health administrative regions of Quebec, supporting collaboration with health services stakeholders to improve access to health services in English and French-speaking communities.
- The Community Health and Social Services Network and the Ministère de la Santé et des Services sociaux partnered to develop accreditation procedures and recommendations for the use of English language interpreters for health and social services in Quebec facilities.
- The Société Santé en français introduced new mental health first aid training adapted to the French-speaking minority communities; these workshops were delivered by the Mental Health Commission of Canada.
- Health Prince Edward Island is incorporating a language identifier on its provincial health insurance card in order to improve and foster the delivery of health services in French.

Strategic Outcome 2: Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians

Program 2.1: *Health Products*

Description

The *Department of Health Act*, and the *Food and Drugs Act* and Regulations provide the authority for Health Canada to develop, maintain, and implement a regulatory framework associated with a broad range of health products that affect the everyday lives of Canadians, including pharmaceutical drugs, biologics and radiopharmaceuticals, medical devices, and natural health products.

Health Canada verifies that the regulatory requirements for the safety, quality, and efficacy of health products are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities.

In addition, Health Canada provides evidence-based, authoritative information to Canadians and key stakeholders, including health professionals such as physicians, pharmacists and natural health practitioners, to enable them to make informed decisions.

The program objective is to ensure that health products are safe, effective, and of high quality for Canadians.

Budgetary Financial Resources (dollars)

2014-15 Main Estimates	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
152,060,884	152,060,884	167,240,719	166,617,222	14,556,338

Note: The variance of $14.6 million between actual and planned spending is mainly due to reallocations of funding from other programs within the Department to support payments to Canadian Thalidomide survivors, and paylist requirements (refer to footnote 3 on page 27 for explanation of paylist requirements).

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
2,089	1,764	-325

Note: The variance in FTE utilization is mainly due to a reflection of workforce requirements based on actual workload and personnel departures that were not backfilled.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Health products available to Canadians on the Canadian market are safe and effective.	% of regulated parties who are deemed to be in compliance with the *Food and Drugs Act* and its associated Regulations.	95 by March 31, 2015	97

Performance Analysis and Lessons Learned

The Canadian health product industry compliance rating was 97%, demonstrating a consistently high level of compliance.

To enhance the integrity of the health product supply chain in Canada and improve the oversight of the ingredients found in health products, the Active Pharmaceutical Ingredients regulations were implemented by Health Canada.

The *Protecting Canadians from Unsafe Drugs Act (Vanessa's Law)* received Royal Assent in November 2014. It amended the *Food and Drugs Act* to improve Health Canada's ability to collect post-market safety information, and take appropriate action when a serious risk to health is identified. It includes a new requirement for certain healthcare institutions to provide Health Canada with information on serious adverse drug reactions and medical device incidents.

New information technology infrastructure tools were implemented across all relevant inspection programs to better support inspections, establishment licensing and incident case management. In addition, the Inspection Tracker[xxvi] and the Drug and Health Product Inspection database[xxvii] have been posted online to provide Canadians with information about Health Canada's inspections as well as a snapshot of current inspection issues that Health Canada is monitoring. Health Canada also began creating Inspection Report Cards for all drug inspections and posting them in the Drug and Health Product Inspection database shortly after each inspection.

The "Drug and Health Product Register[xxviii]" was officially launched on February 12, 2015, a new web tool designed to provide Canadians with easy access to consumer-friendly information on medicines and vaccines in order to better ensure the health and safety of themselves and their families.

As part of increasing transparency, the information available on line for Adverse Event reports was changed to make data publically available when that information is submitted as part of an adverse reaction report. The On-line Adverse Event information is updated quarterly.

An evaluation was completed for the Food and Consumer Safety Action Plan[xxix]. Protecting Canadians from health and safety risks associated with food, consumer products, and health products continues to be a priority of the federal government. Furthermore, the activities initiated under the FCSAP are well-aligned with the strategic outcomes of the partners and with federal roles and responsibilities.

Sub-Program 2.1.1: *Pharmaceutical Drugs*

Description

The *Food and Drug Regulations* provide the regulatory framework to develop, maintain and implement the Pharmaceutical Drugs program, which includes pharmaceutical drugs for human and animal use, including prescription and non-prescription drugs, disinfectants, and sanitizers with disinfectant claims.

Health Canada verifies that regulatory requirements for the safety, quality, and efficacy of pharmaceutical drugs are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities.

In addition, the program provides information to Canadians and key stakeholders, including health professionals, such as physicians and pharmacists, to enable them to make informed decisions about the use of pharmaceutical drugs.

The program objective is to ensure that pharmaceutical drugs in Canada are safe, effective and of high quality.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
59,227,306	76,777,045	17,549,739

Note: The variance between actual and planned spending is mainly due to payments to Canadian Thalidomide survivors, paylist requirements, and realignment of resources between activities (refer to footnote 3 on page 27 for explanation of paylist requirements).

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
1,071	867	-204

Note: The variance in FTE utilization is mainly due to a reflection of workforce requirements based on actual workload and personnel departures that were not backfilled.

Performance Measurement

Expected Results	Performance Indicators	Targets	Actual Results
Pharmaceutical drugs meet regulatory requirements.	% of pharmaceutical product submissions that meet regulatory requirements.	80 by March 31, 2015	75

Expected Results	Performance Indicators	Targets	Actual Results
Canadians and stakeholders are informed of risks associated with the use of pharmaceutical drugs.	% of identified risks that result in risk communications.	80* by March 31, 2015	80**

* The performance target value (80%) refers to the percentage of risk communications that take place within Health Canada's service standard. The service standard can be affected by a complex risk communication development process involving the market authorization holder.

** Health Canada communicated 100% of identified risks. In this instance, 80% of these were within the service standard.

Performance Analysis and Lessons Learned

The first expected result target was not met as 75% of the submissions received met the regulatory requirements compared to the target of 80%. Health Canada held a workshop with the generic industry focussed on improving the quality of drug submissions. The benefits of this workshop are anticipated to be seen in 2015-16. The second expected result target was met as 80% of identified risks were communicated within the service standard. In April 2014, Health Canada started publishing safety summary reviews to the MedEffect Canada website. The publication of review information and associated risk mitigation outcomes ensures transparency and dissemination of safety information to Canadians. Health Canada has now centralized its risk communications process and is meeting service standards.

Under the commitment to use and integrate foreign regulatory information to assist in health product market authorization reviews, Health Canada took a leadership role in international collaborative activities in the review of generic drugs. Under the International Generic Drug Regulators Program, Health Canada launched an information sharing pilot with the European Union that involves receiving scientific assessments of drug applications seeking marketing authorization in “real time”. Under the Australia, Canada, Singapore, Switzerland Consortium, tools such as templates, guidelines, and a common lexicon are being developed to facilitate work sharing. In 2014-15, under the Regulatory Cooperation Council (RCC) initiative, Canada and the United States (U.S.) had one simultaneous veterinary drug approval, and nine drugs submitted for parallel review.

As part of the commitment to improving the safe use of drugs by making drug labels and safety information easier to read and understand:

- The Regulations Amending the Food and Drug Regulations (Labelling, Packaging and Brand Names of Drugs for Human Use) were published in Canada Gazette II in July 2014.
- The revised Guidance for Industry: Drug Brand Name Review[xxx] was posted on the Health Canada website to provide direction to industry in meeting Look-alike Sound-alike brand name assessment requirement.

As part of the commitment to provide Canadians and medical professionals with the most up-to-date drug safety information, Health Canada has published 20 prescriptions and one non-prescription Summary Safety Reviews[xxxi] in plain language for Canadians.

Sub-Program 2.1.2: *Biologics & Radiopharmaceuticals*

Description

The *Food and Drug Regulations*, *Safety of Human Cells, Tissues and Organs for Transplantation Regulations*[xxxii], and the *Processing and Distribution of Semen for Assisted Conception Regulations*[xxxiii] provide the regulatory framework to develop, maintain, and implement the Biologics and Radiopharmaceuticals program, which includes blood and blood products, viral and bacterial vaccines, gene therapy products, tissues, organs, and xenografts, which are manufactured in Canada or elsewhere.

Health Canada verifies that regulatory requirements for the safety, quality, and efficacy of biologics and radiopharmaceuticals are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities.

In addition, the program provides information to Canadians and key stakeholders, including health professionals such as physicians and pharmacists, to enable them to make informed decisions about the use of biologics and radiopharmaceuticals.

The program objective is to ensure that biologics and radiopharmaceuticals in Canada are safe, effective and of high quality.

This program uses funding from the following transfer payments: CBS: Blood Safety and Effectiveness Research and Development, and Contribution to Strengthen Canada's Organs and Tissues Donation and Transplantation System.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
57,184,475	56,447,136	-737,339

Note: The variance between actual and planned spending is mainly due to realignment of resources between activities within Strategic Outcome 2.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
519	429	-90

Note: The variance in FTE utilization is mainly due to a reflection of workforce requirements based on actual workload and personnel departures that were not backfilled.

Performance Measurement

Expected Results	Performance Indicators	Targets	Actual Results
Biologics, Radiopharmaceutical and Genetic Therapies meet regulatory requirements.	% of biologic and radiopharmaceutical, and gene therapy product submissions that meet regulatory requirements.	80 by March 31, 2015	99
Canadians and stakeholders are informed of risks associated with the use of biologics, radiopharmaceuticals, and gene therapies.	% of identified risks that result in risk communications.	80* by March 31, 2015	100

* The performance target value (80%) refers to the percentage of risk communications that take place within Health Canada's service standard. The service standard can be affected by a complex risk communication development process involving the market authorization holder.

Performance Analysis and Lessons Learned

The target for the first expected result was met as 99% of submissions met regulatory requirements. The target for the second expected result was exceeded as 100% of identified risks were communicated. In April 2014, Health Canada started publishing safety summary reviews to the MedEffect Canada website. The publication of review information and associated risk mitigation outcomes ensures transparency and dissemination of safety information to Canadians. Health Canada has now centralized its risk communications process and is meeting service standards.

As part of the commitment to improving the framework for regulating human blood and its components, the final Guidance Document on *Blood Regulations*[xxxiv] was published in October, 2014. The Department continues to assist stakeholders with complying with the *Blood Regulations*.

All changes in oversight required by the blood regulations have been fully implemented and integrated into ongoing inspection operations.

Although Health Canada planned to modernize the regulatory framework for radiopharmaceuticals by bringing this class of drugs under the Drug Identification Number scheme, the work has been delayed and will be incorporated into broader regulatory modernization work in the upcoming year.

To increase transparency of Health Canada's decisions following reviews, Summary Safety Reviews along with a list of ongoing safety reports were developed and posted.

As a result of recommendations from the Biologics Evaluation[xxxv], a process was established for post-market groups to solicit feedback from pre-market regarding review recommendations.

Sub-Program 2.1.3: *Medical Devices*

Description

The *Medical Devices Regulations*[xxxvi] provide the regulatory framework to develop, maintain, and implement the Medical Devices program, which includes medical devices used in the treatment, mitigation, diagnosis, or prevention of a disease or an abnormal physical condition in humans.

Health Canada verifies that regulatory requirements for the safety, quality, and efficacy of medical devices are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities.

In addition, the program provides information to Canadians and key stakeholders, including health professionals, such as physicians and pharmacists, to enable them to make informed decisions about the use of medical devices.

The program objective is to ensure that medical devices in Canada are safe, effective and of high quality.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
14,021,868	11,383,155	-2,638,713

Note: The variance in actual and planned spending is mainly due to a realignment of funding into other areas within the Health Products program, including Pharmaceutical Drugs, Biologics and Natural Health Products based on operational requirements.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
303	263	-40

Note: The variance in FTE utilization is mainly due to a reflection of workforce requirements based on actual workload and personnel departures that were not backfilled.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Medical Devices meet regulatory requirements.	% of applications (Class III and IV*) that meet regulatory requirements. *(Classes I and II present very low health and safety risk to Canadians.)	80 by March 31, 2015	96

Expected Results	Performance Indicators	Targets	Actual Results
Canadians and stakeholders are informed of risks associated with the use of medical devices.	% of identified risks that result in risk communications.	80* by March 31, 2015	100

*The performance target value (80%) refers to the percentage of risk communications that take place within Health Canada's service standard. The service standard can be affected by a complex risk communication development process involving the market authorization holder.

Performance Analysis and Lessons Learned

The target for the first expected result was met. For review decisions 96% of applications met regulatory requirements. Efforts to adapt an electronic review environment are underway and manufacturers are now required to submit applications in electronic formats, which should contribute to improved first review performance in 2015-16. The target for the second expected result was met as 100% of identified risks were communicated. In April 2014, Health Canada started publishing safety summary reviews to the MedEffect Canada website. The publication of review information and associated risk mitigation outcomes contributes to transparency and dissemination of safety information to Canadians. Health Canada has now centralized its risk communications process and is meeting service standards.

As part of the commitment to align Health Canada with other international organizations, the Department worked closely with the U.S., Australia, and Brazil on the Medical Device Single Audit Program, a three-year pilot program which began in January 2014, with the goal to provide a single efficient audit of medical device manufacturers. A single regulatory audit that meets the requirements of each jurisdiction will allow more efficient use of resources and result in more timely access to products for Canadians.

Health Canada also participated in an international consortium of regulatory authorities committed to establishing a single audit program helping to enable market access to participating countries.

Health Canada implemented a regional pilot program to align application format requirements with international regulators. A common approach with minimal regional variations may encourage manufacturers to enter the Canadian market improving access for Canadians.

Sub-Program 2.1.4: *Natural Health Products*

Description

The *Natural Health Product Regulations*[xxxvii] provide the regulatory framework to develop, maintain and implement the Natural Health Products program, which includes herbal remedies, homeopathic medicines, vitamins, minerals, traditional medicines, probiotics, amino acids, and essential fatty acids.

Health Canada verifies that regulatory requirements for the safety, quality, and efficacy of natural health products are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities.

In addition, the program provides information to Canadians and key stakeholders, including health professionals such as pharmacists, traditional Chinese medicine practitioners, herbalists and naturopathic doctors, to enable them to make informed decisions about the use of natural health products.

The program objective is to ensure that natural health products in Canada are safe, effective and of high quality.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
21,627,235	22,009,886	382,651

Note: The variance between actual and planned spending is mainly due to paylist requirements (refer to footnote 3 on page 27 for explanation of paylist requirements).

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
196	205	9

Note: The variance in FTE utilization is mainly due to a realignment of resources within the Health Products program from Medical Devices to Natural Health Products based on operational requirements.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Natural Health Products meet regulatory requirements.	% of natural health product submissions that meet regulatory requirements.	80 by March 31, 2015	94

Performance Analysis and Lessons Learned

As a measure of industry applicants' understanding of regulatory requirements, 94% of natural health product submissions reviewed resulted in a new or amended product licence. The performance result is a direct reflection of the Department's collaborative approach to licensing. By maintaining open lines of communication with applicants, the Department helps industry understand and comply with regulatory requirements; as a result, 10,092 natural health products were licensed or amended during the fiscal year.

The sub-program continues to work toward aligning standards of evidence for products of similar risk; thus allowing for reduced red tape and faster market access for industry for some low-risk product groups, such as sunscreens, while continuing to ensure that the health and safety of Canadians remains the priority.

Highlights included:

- Consulting on a revised approach to site licensing, including conducting a small pilot project to evaluate the feasibility and effectiveness of using third parties for assessing the Good Manufacturing Practice compliance status of Natural Health Products sites.
- Consulting on a new Consumer Health Products Framework aimed providing a consistent approach to products of similar risk (natural health products, cosmetics, non-prescription drugs, disinfectants) whereby requirements would be proportional to the benefit, harm, and uncertainty profile of the products.
- Publishing a new Application Management Policy[xxxviii] and implementing new service standards (10-30-180 days) for natural health products. A webinar series was offered to assist stakeholder's understanding of the revised policy.

Health Canada continued to publish a six-month activity calendar for Natural Health Products[xxxix] that presents an overview of anticipated review activities, publications, workshops and meetings, including new or updated product monographs.

From lessons learned in other product lines, a significantly increased Natural Health Products file tracking architecture was implemented for signal assessments, Periodic Safety Update Report, Risk Management Plans and ad hoc reviews of Natural Health Products. Also, an initiative was launched to work more closely with pre-market directorates to obtain consensus on risk mitigation actions. These initiatives have allowed the program to surpass the newly established surveillance review target of 90% of files meeting target review deadlines, and has greatly improved the ability to deal with Summary Safety Review development.

Program 2.2: *Food Safety and Nutrition*

Description

The *Department of Health Act* and the *Food and Drugs Act* provide the authority for Health Canada to develop, maintain, and implement a regulatory framework associated with the safety and nutritional quality of food. Food safety standards are enforced by the Canadian Food Inspection Agency.

Health Canada develops and promotes evidence-based, national healthy eating policies and standards for Canadians and key stakeholders, including non-governmental organizations, health professionals, and industry associations to enable all stakeholders to make informed decisions about food and nutrition safety as well as healthy eating.

The program objectives are to manage risks to the health and safety of Canadians associated with food and its consumption, and to enable Canadians to make informed decisions about healthy eating.

Budgetary Financial Resources (dollars)

2014-15 Main Estimates	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
59,175,139	59,175,139	66,393,020	66,365,087	7,189,948

Note: The variance of $7.2 million between actual and planned spending is mainly due to additional funding received through Supplementary Estimates to strengthen Canada's food safety oversight system, and paylist requirements (refer to footnote 3 on page 27 for explanation of paylist requirements).

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
594	502	-92

Note: The variance in FTE utilization is mainly due to program hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Foodborne illness, outbreaks and food safety incidents are effectively prevented and managed.	% of the time that Canada maintains a ranking amongst the top five jurisdictions internationally in responding effectively to food safety recalls. (Note: The Food Safety Performance World Ranking initiative is designed to help identify relative strengths and weaknesses in Canada's food safety performance by comparing across 16 countries.)	100 by March 31, 2015	See Note*

Expected Results	Performance Indicators	Targets	Actual Results
Canadians make informed eating decisions.	% of Canadians who consult Health Canada's healthy eating information (e.g. Canada's Food Guide[xl]) to inform their decisions.	40 by March 31, 2016	65

* The "2014 World Ranking of Food Safety Performance" report published by the Food Institute of the University of Guelph and the Conference Board of Canada did not rank countries regarding the response to food safety recalls separately, so that result was not available. However, Canada ranked number one overall amongst 17 Organisation for Economic Co-operation and Development countries for its food safety performance, which includes Canada's ability to respond to food safety recalls.

Performance Analysis and Lessons Learned

The first performance target is considered to be met (see note above on an equivalent survey result).

The second performance target of 40% was surpassed as a Health Canada research study conducted in January 2015 indicated that 65% of respondents report using Health Canada's Nutrition Facts table "always" or "often" when purchasing food.

Work continued to amend Divisions 15 and 16 of the *Food and Drug Act* to eliminate redundancies, provide clarity for stakeholders and help realize the efficiencies provided by the new Marketing Authorization authorities for food additives. Regulations for Division 15 were published in *Canada Gazette, Part I* for public consultation. The proposal aimed to bring together existing rules for contaminants and certain adulterants into a single list that would be incorporated by reference into Division 15 of the *Food and Drugs Regulations*. The regulations also included a proposal to repeal provisions within Schedule E that limits the sale of saccharin as a top sweetener in Canada.

With respect to assessing and managing the risks associated with the priority chemicals under the Chemical Management Plan, Health Canada:

- Published the draft screening assessment report for Ethyl Carbamate in *Canada Gazette, Part I* in July 2014.
- Published the draft screening assessment report for Aromatic Azo and Benzidine-based substance grouping (Amaranth, Tartrazine, New Coccine/Orange II) in *Canada Gazette, Part I* in October 2014.
- Held technical Consultations on arsenic and lead tolerances in fruit juice, fruit nectar, beverages when ready-to-serve, and water in sealed containers.
- Published updated risk management commitments for bisphenol A (BPA) in infant formula in December.

An evaluation was completed for the Food and Consumer Safety Action Plan[xli]. Protecting Canadians from health and safety risks associated with food, consumer products, and health products continues to be a priority of the federal government. Furthermore, the activities initiated under the FCSAP are well-aligned with the strategic outcomes of the partners and with federal roles and responsibilities.

Sub-Program 2.2.1: *Food Safety*

Description

The *Food and Drug Regulations* provide the regulatory framework to develop, maintain, and implement the Food Safety program.

The program is the federal health authority responsible for establishing standards, policies, and regulations pertaining to food and nutrition safety; as well as for conducting reviews and for assessing the safety of food ingredients, veterinary drugs for food producing animals, food processes, and final foods. The program conducts risk assessments pertaining to the chemical, microbiological, and nutritional safety of foods. In addition, the program plans and implements food and nutrition safety surveillance and research initiatives in support of the Department's food standard setting mandate.

The program objective is to plan and implement food and nutrition safety standards to enable Canadians to make informed decisions about food and nutrition.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
54,599,341	60,793,037	6,193,696

Note: The variance between actual and planned spending is mainly due to additional funding received through Supplementary Estimates to strengthen Canada's food safety oversight system, and paylist requirements (refer to footnote 3 on page 27 for explanation of paylist requirements).

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
558	464	-94

Note: The variance in FTE utilization is mainly due to program hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Timely response to emerging food and nutrition safety incidents including foodborne illness outbreaks.	% of health risk assessments provided to the Canadian Food Inspection Agency within standard timelines to manage food safety incidents.	90 by March 31, 2015	100

Performance Analysis and Lessons Learned

The department exceeded its performance target as 100% percent of all Health Risk Assessment requests from the Canadian Food Inspection Agency and federal/provincial/territorial partners were responded to within service standards.

The Department held a series of informal roundtable discussions and launched an online survey to obtain feedback from Canadian parents and consumers on how to improve the way nutrition information is provided on food labels, followed by a more formal consultation.

Guidance was issued to the food industry on:

- Safe Cooking and Handling Labelling for Raw Ground Meat and Raw Ground Poultry[xlii] to provide consistent and appropriate safety information to consumers.
- The labelling requirements for Mechanically Tenderized Beef[xliii] sold in Canada to ensure that industry properly understands the requirements and to ensure that consumers are able to easily identify Mechanically Tenderized Beef and follow the safe cooking instructions provided on the label.

Health Canada developed a format for plain language summaries of Novel Food Decision Documents to provide Canadians with a better understanding of how these foods are approved in Canada. The first plain language summary of a Novel Food Decision Document was published for in March for the Arctic Apple approval.

By leveraging existing service delivery models and solutions developed and implemented within Health Canada, the Department implemented a submission management database to monitor and track its pre-market submissions. The database contains pending and approved submissions for food additives, novel foods and infant formula since April 2014. In addition, a business intelligence tool was implemented in conjunction with the submission management database which provided business analytics and performance reporting capabilities for the three mandatory pre-market submission types above. Further refinements to both tools were also implemented, which will allow the on-boarding of other pre-market submission types in the future.

Sub-Program 2.2.2: *Nutrition Policy and Promotion*

Description

The *Department of Health Act* provides the authority to develop, maintain and implement the Nutrition Policy and Promotion program.

The program develops, implements, and promotes evidence-based nutrition policies and standards, and undertakes surveillance and monitoring activities. It anticipates and responds to public health issues associated with nutrition and contributes to broader national and international strategies.

The program works collaboratively with other federal departments/agencies and provincial/territorial governments, and engages stakeholders such as non-government organizations, health professionals, and industry associations to support a coordinated approach to nutrition issues.

The program objective is to target both Canadian intermediaries and consumers to increase knowledge, understanding, and action on healthy eating.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
4,575,798	5,572,050	996,252

Note: The variance between actual and planned spending is mainly due to paylist requirements (refer to footnote 3 on page 27 for explanation of paylist requirements) and increased requirements in the Healthy Eating Campaign.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
36	38	2

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Stakeholders integrate information on nutrition and healthy eating.	% of targeted stakeholders who integrate Health Canada healthy eating knowledge products, policies, and/or education materials into their own strategies, policies, programs and initiatives that reach Canadians.	80 by March 31, 2016	89

Performance Analysis and Lessons Learned

The Department exceeded its performance targets. An assessment of the use of Canada's Food Guide reported that 89% of targeted stakeholders integrate Health Canada healthy eating knowledge products, policies, and/or education materials into their own strategies, policies, programs and initiatives that reach Canadians. Integration varied across public, private, not for profit sectors.

A more regular review cycle was implemented to ensure Canada's dietary guidance remains scientifically sound, relevant and useful.

During 2014-15, several activities were undertaken to further the implementation of the evidence review cycle:

- The findings from the evidence review cycle were analysed.
- An assessment of the use of Canada's Food Guide was released.
- A stakeholder workshop was hosted at the Canadian Public Health Association's annual conference.

The Department continued to collaborate with stakeholders to help increase Canadians' awareness, understanding and knowledge of healthy eating, including topics such as nutrition labelling, sodium reduction and food skills.

In 2014-15, Health Canada:

- Developed the next phase of the Nutrition Facts Education[xliv] campaign focusing on Serving Size and the Percent Daily Value.
- Developed and disseminated a tool that assesses partnerships with the food industry to ensure potential conflicts of interest are considered and that benefits outweigh risks. A similar tool was also developed to assess collaboration with researchers.
- Continued to work with provincial/territorial, public health authorities, health organizations and retailers to foster a better understanding of how to increase accessibility and availability of nutritious foods – a commitment in the Curbing Childhood Obesity[xlv] framework.
- Developed a new tool called the Eat Well Plate[xlvi], which emphasizes healthy food choices. The Plate concept and related messages aim to help consumers visualize a healthy meal; it conveys proportions of food groups in a healthy eating pattern, with a focus on vegetables and fruit. The accompanying Eat Well Plate e-tool provides consumers with simplified educational messages to help them apply Health Canada's dietary guidance.
- Released new components of the Eat Well and Be Active Educational Toolkit[xlvii] to promote the use and understanding of Canada's Food Guide and Tips to Get Active, including new activity plans, teacher supplements, and improved image gallery and ready to use presentations.
- Provided updates and added new content to the Healthy Eating Toolbox[xlviii], including Vegetable and Fruit fact sheet, Hydration fact sheet, Healthier Grocery Shopping.

Program 2.3: *Environmental Risks to Health*

Description

The *Canadian Environmental Protection Act* and the *Department of Health Act* provide the authorities for the Environmental Risks to Health program to assess and manage the health risks associated with climate change, air quality, drinking water quality, and chemical substances. This program activity links closely with Health Canada's Health Products, Food Safety and Nutrition, Consumer Product Safety and Pesticides program activities, as the *Food and Drugs Act*, the *Pest*

Control Products Act, and the *Canada Consumer Product Safety Act* provide the authority to manage the health risks associated with chemical substances in products in the purview of these program activities.

Key activities include: risk assessment and management as well as research and bio-monitoring of chemical substances; provision of technical support for chemical emergencies that require a coordinated federal response; development of guidelines on indoor and outdoor air quality; development and dissemination of water quality guidelines; and, supporting the implementation of heat alert and response systems (HARS) in Canadian communities.

The program objective is to protect the health of Canadians through the assessment and management of health risks associated with chemical substances and to provide expert advice and guidelines to partners on the health impacts of environmental factors such as air and water contaminants and a changing climate.

Budgetary Financial Resources (dollars)

2014-15 Main Estimates	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
102,849,859	102,849,859	107,392,104	97,967,114	-4,882,745

Note: The variance of $4.9 million between actual and planned spending is mainly due to project delays and a reduction in laboratory maintenance costs partly offset by funding for the retrofit of the Sir Frederick Banting Research Centre in support of the Chemicals Management Plan.

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
720	588	-132

Note: The variance in FTE utilization is mainly due to hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Canadians, institutions and government partners have the guidance and tools they need to respond to potential and actual environmental risks associated with health.	% of planned guidance materials completed.	100 by March 31, 2015	90

Expected Results	Performance Indicators	Targets	Actual Results
Chemical substances deemed to be harmful to human health are managed in a timely manner.	% of substances assessed to be harmful to human health for which at least one risk management instrument was developed by category of substance (new and existing).	100 by March 31, 2015	85

Performance Analysis and Lessons Learned

Health Canada protected the health of Canadians through the assessment and management of health risks associated with chemical substances, and provided expert advice and guidelines to partners on the health impacts of environmental factors such as air and water contaminants and a changing climate.

Health Canada continued to implement the Chemicals Management Plan (CMP). For existing substances, five final risk management instruments, covering six substances, were published for substances deemed harmful to human health (and three of these five instruments covering four substances met the timeframe of publication for final risk management instruments within 18 months following publication of the proposed instrument). For new substances, seven substances were determined to be potentially harmful to human health and 100% of these substances had at least one risk management instrument developed within the mandated timeframe. Combined results for existing substances and new substances risk management reflected 11 of 13 (85%) substances risk managed in 2014-15, with the final two substances currently undergoing internal approval.

In 2014-15, the Department also conducted health risk assessments, health benefit analysis, research and outreach in support of the development of Residential Indoor Air Quality Guidelines, regulations to reduce emissions from transportation as well as proposed health-based Canadian Ambient Air Quality Standards (CAAQS) for sulphur dioxide and nitrogen dioxide, and increased coverage and awareness of the Air Quality Health Index (AQHI). Health Canada also protected the health of Canadians by finalizing five health-based drinking water guidelines/guidance documents approved by provinces/territories and six guidance documents for contaminated sites. For environmental assessments, three out of five guidance documents were completed and await publication (Air Quality, Water Quality and Radiological Effects), while the remaining two are undergoing internal approval. In summary, 18 of 20 guidance materials were completed in 2014-15, accounting for the 90% actual completion rate.

Sub-Program 2.3.1: *Climate Change and Health*

Description

The Climate Change and Health program supports actions to minimize the impact of climate change on the health of Canadians under the federal Clean Air Agenda.

A key activity in the delivery of this program is the Heat Resiliency Project, which aims to inform and advise public health agencies and Canadians on adaptation strategies to respond to extreme heat events.

This includes: development of community-based HARS; development and dissemination of training tools, guidelines, and strategies for health professionals; collaboration with key stakeholders and partners to assess and reduce vulnerabilities to extreme heat; and scientific research on health impacts of extreme heat to support evidence based decision-making.

The program objective is to help Canadians adapt to a changing climate through measures intended to manage potential risks to their health associated with extreme heat events.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
1,432,383	1,716,384	284,001

Note: The variance between actual and planned spending is mainly due to the reporting of actual costs that had been previously planned under Air Quality.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
11	10	-1

Note: The variance in FTE utilization is mainly due to hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Use of knowledge on impacts of climate change on health and adaptation measures by Canadian communities.	# of Canadian Communities with HARS.	12 by March 31, 2016	12

Performance Analysis and Lessons Learned

The program met its target of 12 communities with HARS. Extreme heat poses a growing risk to the health and well-being of Canadians, as climate change is expected to produce heat events with greater intensity, frequency and duration. By implementing appropriate preparation measures such as effective HARS, the health risks of extreme heat can be minimized. In support of the previous fiscal year results, Health Canada shifted its efforts from supporting the development of community-based HARS in at-risk communities to the development of provincial-level systems that would complement the system that is continuing to be supported in Manitoba.

The program continued to assist public health authorities to gain knowledge and prepare to address health impacts during extreme heat events. In 2014-15, research continued with Ontario and Alberta identifying public health actions that should be triggered when a heat alert is declared. In addition, the program worked with 10 Ontario public health authorities and the Pan American Games organising committee to establish heat alert and communications tools to protect athletes and spectators from heat-related illness. This project will inform the broader goal of establishing a provincially consistent approach to HARS in Ontario.

The program also supported knowledge translation and capacity building on an international scale. In conjunction with the Pan American Health Organisation, Health Canada provided assistance to the small island state of Dominica to conduct a climate change and health vulnerability assessment. Within a North American context, the program continued to coordinate the North American Climate Change and Human Health Working Group. This unique group is able to convene policy leads on climate change, human health and meteorological information between Canada, U.S. and Mexico in order to coordinate research, build capacity and exchange information.

Leveraging data collected during heat events was also explored with key partners. These partners were engaged in the interest of data exchange and development to optimize public health activities leading up to and during heat events.

Enhancing community resiliency to extreme heat involves participation of all levels of government and the general public. Success in this program is due to the acknowledgement that the collaborative processes between federal and provincial and local governments, involving a wide range of stakeholders, have been the key to developing HARS, as well as providing technical advice to public health and health professionals.

Sub-Program 2.3.2: *Air Quality*

Description

The Air Quality program assesses the health risks of indoor and outdoor pollutants, and develops guidelines and standards under the *Canadian Environmental Protection Act, 1999*. These efforts support the Government of Canada's Clean Air Regulatory Agenda, implemented in partnership with Environment Canada, to manage the potential risks to the environment and to the health of Canadians associated with air quality.

The program provides health-based science and policy advice that supports actions by all levels of government to improve air quality and health of Canadians. Key activities include: leading the development of health-based air quality standards and guidelines for indoor and outdoor air; determining the health benefits of proposed actions to reduce air pollution; conducting research on the levels of exposure and health effects of indoor and outdoor air pollutants to inform the development of standards, guidelines, regulations and other actions; and, implementing the AQHI in partnership with Environment Canada.

The program objective is to assess the impacts of air pollution on health and to provide guidance to governments, health professionals and the general public on how to minimize those risks.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
23,746,544	18,598,747	-5,147,797

Note: The variance between actual and planned spending is mainly due to the reallocation of resources to urgent issues, including providing significant monitoring and health advice to support local management of the Iqaluit waste facility fire. In addition there was re-scheduling of risk management actions by our partners, and reduced laboratory maintenance costs.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
114	92	-22

Note: The variance in FTE utilization is mainly due to hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Canadians, stakeholders, and governments have access to information on air quality and health effects.	% of Canadians with access to the AQHI.	80 by March 31, 2016	69
	% of planned federal air quality health assessments and risk management actions published or distributed externally.	100 by March 31, 2015	47

Expected Results	Performance Indicators	Targets	Actual Results
Government partners have access to scientific information on the impacts of air quality on health.	% of targeted knowledge transfer activities accomplished related to air quality (e.g. client meetings, poster/ conference presentations and peer-reviewed publications).	95 by March 31, 2015	100

Performance Analysis and Lessons Learned

The ongoing roll out of the AQHI across Canada and other public outreach products improves the ability of Canadians to manage and reduce their exposure to air pollutants on a day-to-day basis. Progress was made to increase the percentage reach to 69%. The expectation is for AQHI's reach to increase to 80% of Canadians by March 31, 2016.

Early and ongoing engagement of all levels of government, non-governmental organizations and industry continues to be essential to ensuring effective actions to address air quality. In 2014-15, Health Canada continued to support implementation of the national Air Quality Management System (AQMS) by: co-leading the multi-stakeholder development of a new CAAQS for sulphur dioxide; conducting health risk assessments to support upcoming development of a CAAQS for nitrogen dioxide; and reviewing the current 2020 standards for fine particulate matter and ozone. As well, the Department worked with Environment Canada and provincial and territorial partners on the implementation of the 2014-17 workplan for the Mobile Sources Working Group under the AQMS to address air pollutants from mobile sources (e.g. motor vehicles).

Health Canada also provided significant monitoring infrastructure, knowledge transfer, and health advice to support local management of the Iqaluit waste facility fire, as part of our on-going support of and cooperation with provincial and territorial partners in response to emergency events.

Significant progress was made on a number of health risk assessments, including diesel fuel, nitrogen dioxide and acetaldehyde, although these progressed more slowly due to the complexities of the analyses. A generic, industrial sector assessment methodology and a rapid screening technique for volatile organic compounds (VOC) were used to improve the efficiency of carrying out certain health assessments. Health Canada also initiated a process to develop a standard to manage VOC emissions from certain building products, led by the Canadian Standards Association.

The air program did not fully meet planned targets for providing health guidance to reduce the risks posed by air pollutants as a number of urgent issues required reallocation of resources, including providing significant monitoring and health advice to support local management of the Iqaluit waste facility fire. There were also additional complexities in risk assessments and re-scheduling of risk management actions by our partners that resulted in delays in completing work in anticipated timelines.

A number of research studies demonstrated improved air quality through the application of ventilation intervention strategies, one of which was quickly implemented by the Ottawa-Carleton District School Board. Continued publication of study results in credible scientific journals ensures that Health Canada science contributes to the body of knowledge on the impacts of air quality on health.

Research on air quality and health generated 95 (100% of planned) knowledge transfer activities including client meetings, reports, publications and presentations. For example, the Canadian Census Health and Environment Cohort study (CanCHEC), a national study examining the long-term effects of exposure to combustion-related pollution from outdoor sources conducted in Canada, provided evidence that was instrumental in developing new CAAQS for fine particulate matter (PM2.5) at levels lower than previously thought to be of concern for health (i.e. 10 ug/m3).

Sub-Program 2.3.3: *Water Quality*

Description

The Water Quality program works with key stakeholders and partners such as the provinces and territories, under the authority of the *Department of Health Act*, to establish guidelines for Canadian drinking water quality, as well as recreational water and household reclaimed water. These guidelines are used by provinces and territories as the basis for establishing their water quality requirements.

The program also works with national and international standard-setting organizations to develop health-based standards for materials that come into contact with drinking water, and works with partners to develop strategies and tools to enhance the safety of small community drinking water supplies.

In the delivery of this program, key activities include the development and dissemination of water quality guidelines/technical guidance documents, strategies and other tools.

The program objective is to help manage potential risks to the health of Canadians associated with water quality.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
3,864,563	3,627,335	-237,228

Note: The variance between actual and planned spending is mainly due to staffing delays.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
35	29	-6

Note: The variance between actual and planned FTEs is due to unstaffed positions.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Federal, provincial and territorial partners use Health Canada water quality guidelines as the basis for their regulatory requirements to manage risks to the health of Canadians.	# of water quality guidelines/guidance documents approved by federal, provincial and territorial Committees.	5 by March 31, 2015	5

Performance Analysis and Lessons Learned

The Water Quality program met its target of five final drinking water quality guidelines/guidance documents approved by provinces and territories. They are: toluene, ethylbenzene, xylenes, tetrachloroethylene (guidelines); and boil water advisories (guidance document). These guidelines are used as the basis for drinking water quality requirements across Canada. In order to achieve this commitment on an ongoing basis, the program works on 20-30 risk assessments simultaneously at any one time. This involves multiple partners/stakeholders to review and discuss scientific, technical and practical aspects for the active risk assessment documents at various stages of development.

The Department, in collaboration with Public Health Agency of Canada (PHAC), also continued to expand the Canadian Network of Public Health Intelligence's drinking water application to more locations. The drinking water application tracks drinking water advisories and the reasons for which they were issued. This will allow the Department to identify trends over time, including reasons for advisories.

Sub-Program 2.3.4: *Health Impacts of Chemicals*

Description

The *Canadian Environmental Protection Act, 1999* provides the authority for the Health Impact of Chemicals program to assess the impact of chemicals and manage the potential health risks posed by new and existing substances that are manufactured, imported, or used in Canada. This program activity links closely with Health Canada's Health Products, Food Safety and Nutrition, Consumer Product Safety and Pesticides program activities, as the *Food and Drugs Act*, the *Pest Control Products Act*, and the *Canada Consumer Product Safety Act* provide the authority to manage the health risks associated with chemical substances in products in the purview of these program activities.

The Chemicals Management Plan (CMP), implemented in partnership with Environment Canada, sets priorities and timelines for risk assessment and management for chemicals of concern, as well as the supporting research and bio-monitoring initiatives.

In addition to the above risk assessment and management activities, this program provides expert health-based advice and support to other federal departments in carrying out their mandates as well as provides technical support for chemical emergencies that require a coordinated federal response.

The program objective is to identify and manage health risks to Canadians posed by chemicals of concern.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
73,806,369	74,024,648	218,279

Note: The variance between actual and planned spending is mainly due to the reporting of actual costs that had been previously planned under Air Quality.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
560	457	-103

Note: The variance in FTE utilization is mainly due to hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Risks associated with chemical substances are assessed.	% of new substances for which industry has sent notification of their manufacture or import that are assessed within targeted timelines.	100 by March 31, 2015	100
	% of total 1,500 existing substances targeted by 2016 assessed.	33 by March 31, 2015	70

Expected Results	Performance Indicators	Targets	Actual Results
Government partners have access to scientific information on how exposure to chemical substances impacts health.	% of targeted knowledge transfer activities accomplished related to chemical substances (e.g. client meetings, poster/conference presentations and peer reviewed publications).	95 by March 31, 2015	100

Performance Analysis and Lessons Learned

In 2014-15, Health Canada continued to implement the CMP. Through the substance groupings and rapid screening initiatives, Health Canada completed draft screening assessment reports (DSARs) for 1,057 substances - 70% of the overall goal of 1,500 substances by March 31, 2016, bringing the cumulative total to 95% as of March 31, 2015. In addition, the cumulative completion rate for final screening assessment reports (FSARs) reached 28% by March 31, 2015. Health Canada is targeting to have the FSARs for approximately 90% of the 1,500 substances published by March 31, 2016.

100% (501) of new substances to the Canadian market were also assessed within targeted timelines in 2014-15. Furthermore, 100% (7) of new substances assessed to be harmful to human health had control measures developed within mandated timeframes. Success was due to the existence of a developed program, early identification of priorities and performance targets, ongoing tracking of progress and adjustment of resources as needed to meet targets.

In 2014-15, analysis of data received under the second phase of the Domestic Substances List Inventory Update (DSL IU2) was completed. The data is being used to update the commercial status of the substances that are remaining priorities for assessment; inform the priority setting for the next phase of the CMP; and support subsequent risk assessment and risk management activities where appropriate.

Health Canada completed 100% (365) of planned knowledge transfer activities such as client meetings, reports, publications and presentations in support of research and monitoring and surveillance activities for the CMP. For example, seven journal articles were published related to the Maternal-Infant Research on Environmental Chemicals study, a national biomonitoring study studying the exposure of pregnant women and their children to priority environmental contaminants and the potential health effects.

The implementation of the Phoenix information and workflow management software has helped the program meet these goals. Communication of progress to stakeholders in a meaningful way was also important, as was the understanding that different stakeholders engage and/or take proactive action at different stages of the CMP cycle. The publication of a regular CMP progress report has been well received by stakeholders as well.

Environmental Assessment and Federal Contaminated Sites Programs

The Environmental Assessment Program provided support and advice on 69 out of 74 projects across the country currently undergoing environmental assessment review (~45 in 2014-15), on effects related to air and water pollution, the contamination of country foods and exposure to noise and radiation. Under the Federal Contaminated Sites Action Plan (FCSAP), Health Canada met all the targets set for the provision of site-specific advice to federal Custodian departments for the assessment, mitigation and risk management of legacy contaminated sites to reduce risks to human health and federal liabilities.

Program 2.4: *Consumer Product and Workplace Chemical Safety*

Description

The Consumer Product and Workplace Chemical Safety program supports efforts to protect Canadians from unsafe products and chemicals.

The Consumer Product Safety program supports industry's responsibility for the safety of their products and consumers' responsibility to make informed decisions about product purchase and use, under the authorities of the *Canada Consumer Product Safety Act* and the *Food and Drugs Act* and its *Cosmetic Regulations*[xlix]. Health Canada's efforts are focussed in three areas: active prevention; targeted oversight; and, rapid response.

The *Hazardous Products Act* and the *Hazardous Materials Information Review Act* provide the authorities for the Workplace Chemical Safety program to maintain a national hazard communication standard of cautionary labelling and material safety data sheets for hazardous chemicals supplied for use in Canadian workplaces and to protect related confidential business information.

The program objectives are to protect Canadians by managing the potential health and safety risks posed by consumer products and cosmetics in the Canadian marketplace and from hazardous chemicals in the workplace.

Budgetary Financial Resources (dollars)

2014-15 Main Estimates	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
37,725,014	37,725,014	37,697,458	34,325,605	-3,399,409

Note: The variance of $3.4 million between total authorities and actual spending is mainly due to reallocations of funding to support efforts on the Globally Harmonized System of Classification and Labelling of Chemicals as well as the deferral of the National Training Program for the Consumer Product Safety Program to 2015-16 to allow for the integration of modernized policies and procedures.

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
301	295	-6

Note: The variance in FTE utilization is mainly due to hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Risks associated with consumer products and cosmetics in the Canadian marketplace are appropriately managed.	% of non-compliant products identified through the Cyclical Enforcement Plan and incident reporting, for which risk management action is taken in accordance with established operating procedures and timelines.	85 by March 31, 2015	96
Confidential Business Information is protected in accordance with the requirements of the *Hazardous Materials Information Review Act.*	# of breaches of confidentiality.	0 by March 31, 2015	0

Performance Analysis and Lessons Learned

In 2014-15, Health Canada took action on non-compliant consumer products and cosmetics approximately 96% of the time within the service standard, much higher than the expected target of 85%. Health Canada continued to monitor the efficiency of its risk management operational procedures to ensure prompt action is taken to reduce the risks posed by dangerous consumer products and cosmetics in the Canadian marketplace. In the spirit of regulatory openness and transparency, Health Canada began posting the results of its cyclical enforcement activities on the web so that compliance information is readily available to the Canadian public. Additionally, a new enforcement approach was piloted at Canada's ports of entry to implement more active prevention techniques in the cyclical enforcement projects, and new inspection approaches were initiated to further evaluate the ability of industry to meet *Canada Consumer Product Safety Act* requirements.

Health Canada provided protection of industry confidential business information in accordance with the requirements of the *Hazardous Materials Information Review Act*, while also ensuring critical health and safety information was available to workers. The Globally Harmonized System (GHS) of Classification and Labelling of Chemicals for workplace chemicals was implemented on February 11, 2015 as part of the Canada-U.S. RCC Action Plan. The implementation of the GHS delivers on the RCC's key initiatives of reducing the regulatory compliance burden, increasing protection of workers, and supporting cooperation with major trading partners.

Sub-Program 2.4.1: *Consumer Product Safety*

Description

The *Canada Consumer Product Safety Act* and the *Food and Drugs Act* and its *Cosmetic Regulations* provide the authorities for this program to support industry's responsibility for the safety of their products and consumers' responsibility to make informed decisions about product purchase and use. Health Canada's efforts are focussed in three areas: active prevention; targeted oversight; and, rapid response.

Through active prevention, the program works with industry, standard setting bodies and international counterparts to develop standards and guidelines and share best practices as appropriate. The program also promotes consumer awareness of the safe use of certain consumer products to support informed decision-making.

Through targeted oversight, the program undertakes regular cycles of compliance and enforcement in selected product categories, and analyses and responds to issues identified through mandatory reporting, market surveys, lab results and other means.

Under rapid response, when an unacceptable risk from consumer products is identified, the program can act quickly to protect the public and take appropriate enforcement actions – including issuing consumer advisories, working with industry to negotiate recalls or other corrective measures.

The Program's objective is to manage the potential health and safety risks posed by consumer products and cosmetics in the Canadian marketplace.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
33,766,919	29,183,362	-4,583,557

Note: The variance between actual and planned spending is mainly due to a transfer of funding to Workplace Chemical Safety to support efforts on the GHS of Classification and Labelling of Chemicals as well as the deferral of the National Training Program for the Consumer Product Safety Program to 2015-16 to allow for the integration of modernized policies and procedures.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
267	254	-13

Note: The variance in FTE utilization is mainly due to the transfer of resources to support efforts on the GHS of Classification and Labelling of Chemicals.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Targeted Canadian industries are aware of regulatory requirements related to consumer products and cosmetics.	% of targeted Canadian industry stakeholders indicating that they are aware of regulatory requirements.	95 by March 31, 2015	95
Early detection of potentially unsafe consumer products and cosmetics.	% of incident reports received and triaged within service standard.	90 by March 31, 2015	99

Performance Analysis and Lessons Learned

Health Canada develops and makes available online numerous guides for industry including Small and Medium-sized Enterprises to help them better understand their obligations under the *Canada Consumer Product Safety Act* and its regulations.

In January 2015, Health Canada released an Industry Guide for the Classification of Cribs, Cradles, Bassinets and Related Products. This guide was in response to a need identified by industry to provide direction on classifying products according to the definitions for “crib”, “cradle” and “bassinet” under the *Cribs, Cradles and Bassinets Regulations*[1]. Members of industry were surveyed on the effectiveness of the Guide. 100% of respondents agreed that the Guide increased their understanding of how to classify their product as per the definitions in the regulations and 91% of respondents agreed that the information was presented in a clear and organized manner.

Health Canada triaged mandatory and voluntary reports to detect potentially unsafe consumer products and cosmetics at the earliest stage possible. These reports were then sent for appropriate risk assessment, risk management or placed under surveillance. In 2014-15, Health Canada received 1,924 reports (61% from industry, 39% from consumer) and triaged 99% of these reports within the service standard, exceeding the performance target of 90%.

Partnering with the U.S and Mexico, Health Canada led the development of joint presentations at two key North American consumer product trade shows – the first time the three agencies have worked together on a technical presentation to industry members. A trilateral presentation on strollers took place at the ABC Kids Expo in Las Vegas in September 2014, while Canada-U.S.

toy safety was presented at the North American International Toy Fair in New York City in February 2015. All three countries also participated in an OECD international outreach campaign on button batteries and laundry detergent packets. In support of continued international cooperation on cosmetic regulations, Health Canada hosted the 8th International Cooperation on Cosmetic Regulation (ICCR) meeting in July of 2014, with representation from the U.S., Japan, the European Union, Brazil and China.

The risk-based approach across all sub-program activities was advanced. The Consumer Product Safety Risk Assessment Framework was developed in December 2014 and the summary was posted on the Health Canada website in March 2015. The sub-program continues to strengthen its surveillance reports and ad hoc analytical activity requests to inform its outreach and compliance and enforcement activities.

Sub-Program 2.4.2: *Workplace Chemical Safety*

Description

The *Hazardous Products Act* and the *Hazardous Materials Information Review Act* provide the authorities for this program to protect the health and safety of Canadian workers.

Under the *Hazardous Products Act*, Health Canada regulates the sale and importation of hazardous chemicals used in Canadian workplaces by specifying the requirements for cautionary labelling and material safety data sheets.

Under the *Hazardous Materials Information Review Act*, Health Canada administers a timely mechanism to allow companies to protect confidential business information, ensuring industry competitiveness, while requiring that all critical hazard information is disclosed to workers.

This program sets the general standards for the Workplace Hazardous Materials Information System (WHMIS) - a system based on interlocking federal, provincial, and territorial legislation that ensures the comprehensibility and accessibility of labels and material safety data sheets, the consistent application of classification and labelling criteria, and the alignment across Canada of compliance and enforcement activities.

The program objective is to ensure a coordinated national system that provides critical health and safety information on hazardous chemicals to Canadian workers.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
3,958,095	5,142,243	1,184,148

Note: The variance between actual and planned spending is mainly due to a reallocation of funding not captured in planned spending, and the adoption and implementation of the Globally Harmonized System of Classification and Labelling of Chemicals.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
34	41	7

Note: The variance in FTE utilization is mainly due to transitional staffing changes as functions and responsibilities were adjusted to accommodate program and organization changes.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Service delivery standards are maintained.	% of claims for exemption registered within 7-day service standard.	100 by March 31, 2015	77

Performance Analysis and Lessons Learned

Of the completed claims for exemption under the *Hazardous Materials Information Review Act*, 77% were registered within the seven-day service standard over the course of the year. Organizational and business process changes implemented through the course of 2014-15 resulted in some initial delays given the adjustments that needed to be made. However, the process improvements were evident by the last quarter, during which 94% of claims were registered within the seven-day service standard. These process improvements will ultimately improve Health Canada's ability to meet the performance target of 100% for the registration of claims for exemption under *Hazardous Materials Information Review Act*.

On February 11, 2015, the Government of Canada published the *Hazardous Products Regulations* in the Canada Gazette, Part II which, in addition to the amendments made to the *Hazardous Products Act*, modified the WHMIS 1988 to incorporate the GHS for workplace chemicals (WHMIS 2015). By adopting the GHS, Canada has achieved the Canada- U.S. RCC Joint Action Plan objective of reducing trade barriers and providing benefits for all stakeholders by reducing costs for suppliers, and ensuring employers and workers have access to consistent and coherent hazard information. The two countries will continue to align and synchronize the implementation of the GHS.

Program 2.5: *Substance Use and Abuse*

Description

Under the authority of several Acts, the Substance Use and Abuse program regulates tobacco products and controlled substances.

Through the *Tobacco Act* and its regulations the program regulates the manufacture, sale, labelling and promotion of tobacco products. The program leads the Federal Tobacco Control

Strategy (FTCS), the goal of which is to further reduce the prevalence of smoking through regulatory, programming, educational and enforcement activities.

Through the *Controlled Drugs and Substances Act* and its regulations, the program regulates access to controlled substances and precursor chemicals to support their legitimate use and minimize the risk of diversion for illicit use. As a partner department under the National Anti-Drug Strategy (NADS), the program supports prevention, health promotion, treatment initiatives, and enforcement with the goal of reducing substance use and abuse.

In addition, the program provides timely, evidence-based information to key stakeholders including, but not limited to, law enforcement agencies, health professionals, provincial and territorial governments and Canadians.

The program objective is to manage risks to the health of Canadians associated with the use of tobacco products, and the illicit use of controlled substances and precursor chemicals.

Budgetary Financial Resources (dollars)

2014-15 Main Estimates	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
82,748,939	82,748,939	74,460,754	69,339,368	-13,409,571

Note: The variance of $13.4 million between actual and planned spending is mainly due to revised implementation timelines for contribution agreements.

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
368	409	41

Note: The variance in FTE utilization is mainly due to an increase in resources for Preventing Prescription Drug Abuse, Controlled Substances, and *Marihuana for Medical Purposes Regulations*[li].

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Reduction in tobacco prevalence.	% of current Canadian (aged 15+) smokers reduced.	<17 by March 31, 2015	15
Reduction in illicit drug use.	% of Canadians (aged 15+) who abuse psychoactive drugs reduced.	<10 by March 31, 2015	11
	% of youth (aged 15-24) who abuse psychoactive drugs reduced. Note: The % of	<23 by March 31, 2015	25

Expected Results	Performance Indicators	Targets	Actual Results
	Canadians who abuse psychoactive drugs is defined as using at least one of the following substances at least once in the past 12 months: cannabis, cocaine/crack, meth/crystal meth, ecstasy, hallucinogens, salvia, inhalants, heroin and pain relievers, stimulants or sedatives to get high.		

Performance Analysis and Lessons Learned

Health Canada has continued to make progress on priorities related to tobacco control and combatting substance use and abuse.

The first biennial Canadian Tobacco, Alcohol and Drugs Survey 2013 was released in February 2015. The survey, conducted by Statistics Canada on behalf of Health Canada, focuses on smoking behaviors, alcohol use, illicit drug use, and prescription drug abuse in Canadians 15 years of age and older.

Few other countries have been as successful as Canada in lowering smoking rates and shifting public attitudes about tobacco. Smoking prevalence is now at its lowest-ever overall rate. The 2013 survey results found that 15% of Canadians were current cigarette smokers, down from 22% in 2001 and the lowest national smoking rate ever recorded. Further, the prevalence rate for teens aged 15-17 is 6%, the lowest it has ever been.

The 2012-17 FTCS refocused activities in tobacco control to continue the downward trend in smoking prevalence, including investments in new priorities for young adults and First Nations and Inuit populations with higher smoking rates. Health Canada, which leads the FTCS, undertook a variety of regulatory, programming, educational and enforcement activities to further reduce smoking prevalence.

Health Canada also continued to undertake a wide range of activities with respect to controlled substances through the *Controlled Drugs and Substances Act* and under the federal NADS, which was expanded in 2014 to include prescription drug abuse. Activities in 2014 focussed on ongoing enforcement of the *Controlled Drugs and Substances Act*, raising public awareness about the harmful effects of prescription drug abuse and marijuana, and providing support for the development of tools and community-based initiatives focussed on the prevention and treatment of illicit drug use and prescription drug abuse.

The 2013 survey results found that the use of at least one of six illicit drugs in the past 12 months (cannabis, cocaine or crack, speed, ecstasy, hallucinogens or heroin) was reported by 11% of Canadians, and is not different from 2012. 25% of youth (aged 15-24) also reported using psychoactive drugs at least once in the past 12 months. The most commonly reported illicit drugs after cannabis (cocaine/crack, meth/crystal meth, ecstasy, hallucinogens, salvia, inhalants, heroin and pain relievers, stimulants or sedatives) were estimated to be less than 1%. There were no changes in prevalence of use of any of these drugs individually, between 2013 and 2012.

Sub-Program 2.5.1: *Tobacco*

Description

The *Tobacco Act* provides the authority for the Tobacco program to regulate the manufacture, sale, labelling, and promotion of tobacco products.

The program also leads the FTCS, in collaboration with federal partners as well as provincial and territorial governments, which supports regulatory, programming, educational and enforcement activities.

Key activities under the Strategy include: compliance monitoring and enforcement of the regulations under the *Tobacco Act* and associated regulations; monitoring tobacco consumption and smoking habits; and, working with national and international partners to ensure that Canada meets its obligations under the Framework Convention on Tobacco Control.

The program objective is to prevent the uptake of tobacco use, particularly among youth, help those who currently use tobacco to quit and protect Canadians from exposure to tobacco smoke.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
26,779,195	19,710,266	-7,068,929

Note: The variance between actual and planned spending is mainly due to lower than anticipated provincial and territorial funding requirements for the pan-Canadian Quitline and reallocations of funding within the Substance Use and Abuse program.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
121	110	-11

Note: The variance in FTE utilization is mainly due to attrition and voluntary departures.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Industry is compliant with the *Tobacco Act* and its regulations.	% of products that are deemed to be non-compliant with the *Tobacco Act* and its regulations related to manufacturing and importing.	<5 by March 31, 2015	4

Performance Analysis and Lessons Learned

National smoking rates continue to be at their lowest level ever recorded. In 2014-15, Health Canada provided funding to provinces and territories to support the pan-Canadian, toll-free Quitline number and portal, and continued to work with First Nation communities as well as partners in the public and private sectors on projects to promote healthy living and prevent chronic diseases caused by tobacco.

Health Canada, in collaboration with the Canadian Cancer Society, also launched the "Break it Off Campaign" in Vancouver in January 2014 during National Non-Smoking Week. The Break it Off Campaign is a young adult tobacco cessation, awareness and marketing campaign that will run until 2017.

Health Canada also conducted compliance monitoring and enforcement activities pursuant to the *Tobacco Act*. Inspections found 4% of regulated tobacco products examined were non-compliant with the *Tobacco Act* and its regulations.

Health Canada distributed over 80,699 tobacco publications and responded to over 500 public enquiries on tobacco issues in 2014-15. Furthermore, Health Canada contributed, as a key facilitator, to the working group report on the implementation of Articles 9 and 10 of the tobacco product regulations and disclosure of the Conference of the Parties to the World Health Organization Framework Convention on Tobacco Control.

Finally, the proposed Order Amending the Schedule to the *Tobacco Act* and the associated Regulatory Impact Analysis Statement was pre-published in the March 7, 2015 edition of the *Canada Gazette, Part I*. The proposal concerns the protection of youth from inducements to use tobacco products by further limiting the availability of flavoured cigar types that are attractive to youth.

Sub-Program 2.5.2: *Controlled Substances*

Description

Through the administration of the *Controlled Drugs and Substances Act* and its regulations, the program authorizes the possession, production, provision and disposition of controlled substances and precursor chemicals.

Key activities include: maintaining and updating the Schedules for controlled substances and precursor chemicals; administering regulations for licensing and compliance monitoring activities; analyzing seized materials; providing training and assistance in investigating and dismantling of clandestine laboratories (Drug Analysis Services); monitoring the use of drugs through surveys; and working with national and international partners in the development of sound and scientifically based recommendations for the analysis of Illicit drugs available to Drug Analysis Laboratories worldwide.

As a partner in the NADS, Health Canada supports initiatives related to illicit drugs including: education; prevention; health promotion; and treatment for Canadians, as well as compliance and enforcement initiatives.

The program objective is to authorize legitimate activities with controlled substances and precursor chemicals, while managing the risks of diversion, abuse and associated harms.

This program uses funding from the following transfer payments: Drug Strategy Community Initiatives Fund, Drug Treatment Funding Program, and Grant to the Canadian Centre of Substance Abuse.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
55,969,744	49,629,102	-6,340,642

Note: The variance between actual and planned spending is mainly due to revised implementation timelines for contribution agreements.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
247	299	52

Note: The variance in FTE utilization is mainly due to an increase in resources for Preventing Prescription Drug Abuse, Controlled Substances, and implementing the *Marihuana for Medical Purposes Regulations*.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Holders of licences, authorizations and permits for controlled substances and precursor chemicals are compliant with the Controlled Drugs and Substances Act and its regulations.	% regulated parties that are deemed to be compliant with the Controlled Drugs and Substances Act and its regulations.	95 by March 31, 2015	99
Recipients of federal funding are enabled to deliver drug treatment and prevention programs.	# of funded projects delivering drug treatment and prevention programs.	55 by March 31, 2015	56

Performance Analysis and Lessons Learned

Pursuant to its role as a regulator under the *Controlled Drugs and Substances Act*, Health Canada continued to conduct annual compliance monitoring and enforcement activities for controlled substances and precursor chemicals. Less than 1% of inspected parties were found to be non-compliant with the *Controlled Drugs and Substances Act* and its regulations.

In 2014-15, 46 projects were supported under the Drug Strategy Community Initiative Fund (DSCIF), including 6 projects targeting the prevention of prescription drug abuse. Projects reported reaching over 89,400 youth, parents, teachers and other community organizations and individuals. A 2014-15 evaluation of DSCIF[lii] concluded that DSCIF was successful at enhancing capacity among targeted populations; reducing risk-taking behaviours associated with substance use; increasing the uptake of health promotion, prevention knowledge and resources; and increasing community engagement. The program has begun actions for all areas identified in the management response and action plan.

Limited performance data was available in 2014-15 to support reporting against the Drug Treatment Funding Program (DTFP) outcomes due to the majority of 13 contribution agreements being signed late in the fiscal year. However, some projects reported improved collaboration and knowledge exchange and access to evidence-informed information. Projects have also reported consulting over 1,700 individuals reaching over 40,000 individuals.

In late 2014-15, DSCIF and DTFP were merged into one program - the Anti-Drug Strategy Initiatives (ADSI).

Health Canada undertook consultations related to regulating tamper-resistant properties for prescription drugs at high risk of abuse, and for regulating dangerous precursor chemicals and synthetic drugs.

Health Canada also continued to implement the new *Marihuana for Medical Purposes Regulations* (published in the *Canada Gazette, Part II* in June 2013). As part of the ongoing implementation, the Program carried out significant compliance and enforcement activities, including conducting regular unannounced inspections. For 2014-15, 246 inspections were conducted. In addition, there were five recalls of dried marijuana, and 22 warning letters were sent regarding non-compliant advertising activities.

Health Canada supported the parliamentary process for Bill C-2, which amended the *Controlled Drugs and Substances Act* to set out specific criteria that applicants must address before seeking an exemption from Health Canada to create a supervised consumption site. Health Canada also launched a new public awareness campaign that focused on drug abuse issues.

Program 2.6: *Radiation Protection*

Description

The *Department of Health Act*, the *Radiation Emitting Devices Act*, and the *Comprehensive Nuclear-Test-Ban Treaty Implementation Act*[liii] provide the authority for the Radiation Protection program to monitor, regulate, advise, and report on exposure to radiation that occurs both naturally and from man-made sources. In addition, the program is licensed under the Canadian Nuclear Commission's *Nuclear Safety and Control Act*[liv] to deliver the National Dosimetry Service, which provides occupational radiation monitoring services.

The key components of the program are environmental monitoring, provision of technical support for a radiological/nuclear emergency that requires a coordinated federal response, occupational safety, and regulation of radiation emitting devices.

The program objective is to inform and advise other government departments, international partners, and Canadians in general about the health risks associated with radiation, and inform Canadians of strategies to manage associated risks.

Budgetary Financial Resources (dollars)

2014-15 Main Estimates	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
20,522,668	20,522,668	21,345,176	20,709,033	186,365

Note: The variance of $0.2 million between actual and planned spending is mainly due to a transfer from National Defence to support the Canadian Safety and Security Program.

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
209	195	-14

Note: The variance in FTE utilization is mainly due to hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Canadians, Institutions and Government partners have the guidance they need to respond to potential and actual radiation risk.	% of planned guidance documents completed. Note: Guidance documents include emergency plans, safety codes, regulations, Memorandums of Understanding.	80 by March 31, 2015	80

Performance Analysis and Lessons Learned

Heath Canada completed the targeted number of guidance documents, which were used to support National Radon Program outreach activities and to increase Canadians' awareness and understanding of risks related to radiation emitting devices.

The Department continued to increase awareness of the risks, health impacts and mitigation strategies related to exposure to indoor air contaminants. Health Canada supported and participated in the 2nd annual National Radon Action Month in November 2014 led by the New Brunswick Lung Association. The aim is to encourage all Canadians to test the levels of radon gas in their homes, and to reduce the radon levels if necessary

In support of increasing Canadians' awareness and understanding of risks related to radiation emitting devices, Health Canada concluded and published its preliminary findings from the *Wind Turbine Noise and Health Study*. In addition the Department updated its Radiofrequency Exposure Guidelines in a document entitled: *Limits of Human Exposure to Radiofrequency Electromagnetic Energy in the Frequency Range from 3 kHz to 300 GHz - Safety Code 6 (2015)*. This code is accompanied by the Technical Guide for Interpretation and Compliance Assessment of Health Canada's Radiofrequency Exposure Guidelines, to assist users in understanding and assessing the safety of electromagnetic exposures in working and living environments.

Health Canada is also the lead federal department responsible for coordinating the response to a nuclear emergency under the Federal Nuclear Emergency Plan (FNEP). As part of a series of exercises to test the revised FNEP, 5th edition, a national-level emergency preparedness exercise (Exercise Unified Response) was conducted in May 2014. Exercise Unified Response successfully validated the FNEP and results from this exercise will be used to identify areas for improvement, implement corrective actions, and support ongoing nuclear emergency preparedness.

Sub-Program 2.6.1: *Environmental Radiation Monitoring and Protection*

Description

The Environmental and Radiation Monitoring and Protection program conducts research and monitoring activities under the authority of the *Department of Health Act* and the *Comprehensive Nuclear-Test-Ban Treaty Implementation Act*. The program covers both naturally occurring forms of radioactivity and radiation, such as radon, and man-made sources of radiation, such as nuclear power.

In the delivery of this program, key activities include: implementing an education and awareness program on the health risks posed by radon in indoor air and how to reduce those risks; conducting research and risk assessment on the health effects of radiation; installing and operating monitoring stations to monitor for evidence of any nuclear explosion; and, reporting to the Comprehensive Nuclear-Test-Ban Treaty Organization and the International Atomic Energy Agency.

This program is also responsible for coordinating the FNEP. In the case of a radio-nuclear emergency that requires a coordinated federal response, Health Canada coordinates the federal technical/scientific support to provincial and territorial.

The program objectives are to monitor and help inform Canadians of potential harm to their health and safety associated with environmental radiation.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
14,414,866	13,698,164	-716,702

Note: The variance between actual and planned spending is mainly due to a portion of the planned spending in this program that should have been allocated to Dosimetry Services.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
100	98	-2

Note: The variance in FTE utilization is mainly due to hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Health Canada is prepared to respond to a nuclear or radiological emergency.	# of emergency preparedness exercises performed (in accordance to expectations of internal and external partners.)	2 by March 31, 2015	6
Environmental radiation is monitored.	% of national radionuclear and Comprehensive Nuclear-Test-Ban Treaty monitoring stations and laboratories that are operational.	90 by March 31, 2015	98
Targeted partners collaborate to address health risks related to radiation/radon.	% of targeted partners participating in education and awareness and communication activities.	80 by March 31, 2015	100

Performance Analysis and Lessons Learned

As lead department for coordinating the federal response to a nuclear emergency, Health Canada conducted a number of exercises and drills, including a national-level exercise (Exercise Unified Response), to identify any problems, inadequacies, or gaps in preparedness and response plans so that these issues could be resolved prior to a real emergency. In preparation for the Pan-American and Para-Pan American Games to be held in July and August 2015 there were a number of meetings, drills and exercises to test arrangements and confirm roles and responsibilities, as well as training on emergency management applications.

Health Canada continued to meet international and national requirements related to environmental radiation monitoring. Environmental radiation monitoring activities support Canada's obligations under the Comprehensive Nuclear-Test-Ban-Treaty. 98% of national radionuclear and Comprehensive Nuclear-Test-Ban Treaty monitoring stations and laboratory capabilities were operational throughout the year.

The Department, in collaboration with key stakeholder partners, also continues to increase awareness on the health impacts related to indoor radon exposure and the actions Canadians can take to reduce their risk. In November 2014, Health Canada participated in the 2nd annual National Radon Action Month to encourage all Canadians to test the levels of radon gas in their homes and to reduce radon levels if necessary. As part of this initiative, 100% of targeted partners participated in education and awareness activities that included public presentations and the distribution of radon awareness materials at home shows, conferences, community and health centres.

The radon federal building testing program tested 2,500 federal buildings in 2014-15. Since the start of the program in 2007, approximately 17,500 federal buildings have been tested for radon. In addition, the database of indoor radon concentrations was maintained and updated as new information was acquired from radon surveys, radon measurement service providers and members of the public.

Sub-Program 2.6.2: *Radiation Emitting Devices*

Description

Under the authority of the *Radiation Emitting Devices Act*, this program regulates radiation emitting devices, such as equipment for clinical/analytical purposes (X-rays, mammography, ultrasound), microwaves, lasers, and tanning equipment.

In the delivery of this program, key activities include: compliance assessment of radiation emitting devices at federally regulated facilities, research into the health effects of radiation (including noise, ultraviolet, and non-ionizing radiation from wireless devices such as cell phones and WiFi equipment); and, development of standards and guidelines for the safe use of radiation emitting devices.

The program provides expert advice and information to Canadians, as well as to other Health Canada programs, federal departments, and provincial authorities so that they may fulfil their legislative mandates.

The program objective is to manage the risks to the health of Canadians from radiation emitting devices.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
5,413,387	4,658,791	-754,596

Note: The variance between actual and planned spending is mainly due to reallocations of funding to Health Impacts of Chemicals, and the reporting of expenditures for the Beyond the Border Action Plan under another program within Health Canada's Program Alignment Architecture.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
38	37	-1

Note: The variance in FTE utilization is mainly due to hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Canadians have timely access to information on the health risks related to consumer and clinical radiation emitting devices.	% of public inquiries responded to within five business days.	90 by March 31, 2015	76
Institutions are enabled to take necessary action against radiation emitting devices that are non-compliant.	% of assessment and/or inspection reports completed upon request from institutions.	90 by March 31, 2015	100

Performance Analysis and Lessons Learned

Health Canada responded to 654 public inquiries associated with radiation emitting devices (e.g. via the 1-800-O-Canada line, email, etc.). Many of the inquiries related to the potential health effects of electric and magnetic fields, ultraviolet, infrared and visible light radiation and acoustics from consumer devices and manmade environmental sources. While the program developed generic responses for general and repeated inquiries to better meet the five-day response standard, with the complexity of many of the inquiries, the response rate still exceeded the five day business standard that was in place for 2014-15 (76% of public inquiries were responded to within five business days). Health Canada has revised the target for 2015-16 from five to ten days to allow for adequate time for response. Health Canada also completed all requested assessments and/or inspection reports from institutions and responded to 230 inquiries from stakeholders. Most inquiries from stakeholders were for elaboration/interpretation of regulatory requirements under the *Radiation Emitting Devices Act*. In addition, a cyclical enforcement plan for radiation emitting devices regulated under the *Radiation Emitting Devices Act* was developed and implemented based on a risk evaluation of these products.

Health Canada also released its preliminary findings for the Wind Turbine Noise and Health Study. Health Canada, in partnership with Statistics Canada, had conducted a two-year study to better understand the impacts of wind turbine noise on health.

Sub-Program 2.6.3: *Dosimetry Services*

Description

The Dosimetry Services program monitors, collects information, and reports on the exposure to radiation of its clients, occupational radiation workers under the licence of the Canadian Nuclear Safety Commission's *Nuclear Safety and Control Act*, and/or provincial/territorial regulations.

Dosimetry is the act of measuring or estimating radiation doses and assigning those doses to individuals.

The National Dosimetry Services provides radiation monitoring services on a cost-recovery basis to Canadians exposed to ionising radiation in their places of work, and, the National Dose Registry provides a centralized radiation dose record system.

The program objective is to ensure that Canadians exposed to radiation in their places of work who are monitored by the Dosimetry Services program are informed of their radiation exposure levels.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
694,415	2,352,078	1,657,663

Note: The variance between actual and planned spending is mainly due to the reallocation of funding to purchase items associated with the service delivery of this program, as well as the reporting of actual costs that had been previously planned under Environmental Radiation Monitoring and Protection.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
72	60	-12

Note: The variance in FTE utilization is mainly due to hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Occupational radiation workers and their employers are informed of their exposure level.	% of dosimeters reported within 10 days of receiving client dosimeters.	90 by March 31, 2015	91
	% of dose history reports sent to clients within 10 days of receipt of request.	100 by March 31, 2015	100
	% of overexposure readings reported to Regulatory Authorities within 24 hours of dose information received into the National Dose Registry.	100 by March 31, 2015	100

Performance Analysis and Lessons Learned

Health Canada provided timely and reliable dosimetry services to 12,500 client groups. The Department processed and reported 91% of dosimeter readings to client groups and the National Dose Registry within 10 days of receipt and 100% of dose history reports were sent to clients within 10 days of receipt of request. 100% of overexposure readings were reported to Regulatory Authorities within 24 hours of dose information received into the National Dose Registry.

Program 2.7: *Pesticides*

Description

The *Pest Control Products Act* provides Health Canada with the authority to regulate and register pesticides, under the Pesticides program.

In the delivery of this program, Health Canada conducts activities that span the lifecycle of a pesticide, including: product assessment for health and environmental risks and product value; risk management; post market surveillance; compliance and enforcement; changes in use, cancellation, or phase out of products that do not meet current standards; and, consultations and public awareness building.

Health Canada is also an active partner in international efforts (e.g., North American Free Trade Agreement; Organization for Economic Cooperation and Development (OECD), RCC to align regulatory approaches. These engagements provide access to the best science available to support regulatory decisions and promote consistency in the assessment of pesticides.

The program objective is to protect the health and safety of Canadians and the environment relating to the use of pesticides.

Budgetary Financial Resources (dollars)

2014-15 Main Estimates	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
40,651,125	40,651,125	45,426,812	44,319,169	3,668,044

Note: The variance of $3.7 million between actual and planned spending is mainly due to paylist requirements (refer to footnote 3 on page 27 for explanation of paylist requirements) and revenues collected in excess of authorities.

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
512	416	-96

Note: The variance in FTE utilization is mainly due to an overstatement of planned FTEs resulting from historical calculations which used average salary figures that are below actual.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Industry meets the Canadian regulatory requirements for new pesticides.	% of submissions that meet regulatory requirements.	80 by March 31, 2015	94
Pesticides in the marketplace continue to meet modern scientific standards.	% of registered pesticides that are re-assessed according to the Re-evaluation Work Plan.	80 by March 31, 2015	86
International collaboration is leveraged to maximize access to global science for the risk assessment of pesticides.	% of new pesticides reviewed in collaboration with international partners.	80 by March 31, 2015	100

Performance Analysis and Lessons Learned

Health Canada continued to deliver on its responsibilities under the *Pest Control Products Act* through the evaluation and re-evaluation of pesticide products (even while receiving a significant number of requests for special reviews), compliance and enforcement, and outreach and risk reduction strategies. Health Canada maintained quality and exceeded performance targets on all core regulatory activities through prudent management of its pesticide program.

Health Canada continued its international collaboration with partners in standardizing and harmonizing global approaches to modern science. Through both the Canada-U.S. RCC and the Organization for OECD, PMRA expanded the use of joint reviews, which facilitate same time access as competitors to new pesticide technology for Canadian growers. Furthermore, Health Canada has a close working relationship with the U.S.-EPA and collaborates with them on all new Active Ingredients. Partnerships with other North American and international regulators, as well as industry partners, have resulted in the development of a pollinator risk assessment framework resulting in mitigation measures to protect pollinators. The Department also completed an update to the Maximum Residue Limits database for various Crop Groups, which is pending release by Shared Services Canada. Four new active ingredients, along with their associated end use products, were reviewed via global/NAFTA joint-reviews.

Health Canada completed 100% of planned Active Prevention and Targeted Oversight program activities and continued with compliance and enforcement policy and procedure development, to support delivery of core regulatory activities. A new logic model related to compliance and enforcement activities and performance measurement framework was approved, and data sources for indicators were identified. Also, initiatives were undertaken with the U.S.-EPA and OECD to improve timely information sharing of global pesticide risk information on the illegal trade of pesticides.

Health Canada initiated work on the development of an IM/IT Framework while advancing specific Investment Plan projects in support of renewing core e-business systems that will ultimately strengthen reporting on the full product life cycle. Public consultation on a revised cost recovery regime was completed and a pre-proposal notice was published for consultation in March 2015. In early April 2015, the Pesticide Cost Recovery Official Notice of Fee Proposal was tabled in both Houses.

Strategic Outcome 3: First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status

Program 3.1: *First Nations and Inuit Primary Health Care*

Description

The *Department of Health Act* 1996, and the *Indian Health Policy* (1979)[lv] provide the authority for the delivery of the First Nations and Inuit Primary Health Care program to First Nations and Inuit in Canada. Primary health care includes health promotion and disease prevention, public health protection (including surveillance), and primary care (where individuals are provided diagnostic, curative, rehabilitative, supportive, palliative/end-of-life care, and referral services).

The Department administers contribution agreements and direct departmental spending related to child development, mental wellness and healthy living, communicable disease control and management, environmental health, clinical and client care, as well as home and community care.

The program objective is to improve the health and safety of First Nations and Inuit individuals, families, and communities.

Budgetary Financial Resources (dollars)

2014-15 Main Estimates	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
853,702,552	853,702,552	884,879,027	870,774,016	17,071,464

Note: The variance of $17.1 million between actual and planned spending is mainly due to the net of the following:

- Variance of $31.1 million between planned spending and total authorities is mainly due to additional funding received through Supplementary Estimates to support the delivery of the First Nations Water and Wastewater Action Plan as well as prescription drug abuse programming;
- Variance of $14.1 million between total authorities and actual spending is mainly due to a surplus of funding in the Indian Residential Schools Resolution Health Support Program due to its demand driven nature, and realignments within this strategic outcome to meet program needs.

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
1,081	1,361	280

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. Health Canada receives annual growth of 3% on a portion of First Nation and Inuit Primary Health Care programs. These funds are appropriated as Operating funds. Consistent with program authorities approved by Treasury Board, Health Canada realigned resources based on program needs from Operating to Salaries; therefore, Actual FTE Utilization is higher than Planned. The Department plans to make adjustments in future Main Estimates to reflect current business requirements now that DPRs are reporting at the Sub-Sub Program levels.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Health and safety of First Nations and Inuit are improved.	% of First Nations adults reporting being in excellent or very good health.	45* by March 31, 2017	44
	% of Inuit adults reporting being in excellent or very good health.	50.5** by March 31, 2017	42
	% of primary health care programs delivered to First Nations and Inuit that incorporate cultural approaches into programming.	80 by March 31, 2017	100

* The percentage of First Nations living on reserve who rate their health "Excellent" or "Very Good" has increased by 10% since 2002-03. Achievement of this target will represent an additional increase of 2%. The percentage of Canadians overall who rate their health as "Excellent" or "Very Good" has remained relatively stable over the same period, at around 57%[4].

** Based on data from the Aboriginal People's Survey, this target will represent an increase of 20% from 2012. Refer to footnote 4 for further context on performance measurement targets.

Performance Analysis and Lessons Learned

The performance targets for First Nations and Inuit adults reporting being in excellent or very good health are on target for being met on March 31, 2017, as current data indicate that this is the case for 44% of First Nations and 42% of Inuit adults. 100% of primary health care programs delivered to First Nations and Inuit incorporated cultural aspects into their programming, exceeding the target of 80%.

---

[4] Health Canada continues to work with partners to aim for the best health system and health outcomes for First Nations and Inuit. In some instances, annual targets do not represent the desired final outcome, but rather interim targets based on the best evidence available that Health Canada can monitor progress, on an annual basis. Health Canada continues to monitor trends over time to support refinement of its targets and improved performance measurement.

In 2014-15, Health Canada continued to enhance access to services to help strengthen primary care for First Nations and Inuit communities. For example, a draft set of core standards was completed and engagement was initiated with First Nations and Inuit stakeholders to ensure a shared vision and commitment to standards implementation.

Health Canada enhanced new models of care which involved a comprehensive series of interwoven reforms intended to strengthen service delivery, respond more effectively to health service needs, address system sustainability, foster healthy individuals, healthy families, and healthy communities and ultimately lead to a modern, sustainable, high quality health service in remote and isolated First Nations communities.

These reforms included reorienting service delivery models to interprofessional teams, addressing service access issues, optimizing technology, information management and infrastructure and strengthening community voice and a focus on population health.

Sub-Program 3.1.1: *First Nations and Inuit Health Promotion and Disease Prevention*

Description

The First Nations and Inuit Health Promotion and Disease Prevention program delivers health promotion and disease prevention services to First Nations and Inuit in Canada.

The program administers contribution agreements and direct departmental spending for culturally appropriate community-based programs, services, initiatives, and strategies. In the delivery of this program, the following three key areas are targeted: healthy child development; mental wellness; and healthy living.

The program objective is to address the healthy development of children and families, to improve mental wellness, and to reduce the impacts of chronic disease on First Nations and Inuit individuals, families, and communities.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
465,019,189	476,741,545	11,722,356

Note: The variance between actual and planned spending is mainly due to the reallocation of funding from other programs within this strategic outcome to meet program needs, which is partly offset by a surplus in the Indian Residential Schools Resolution Health Support Program due to the demand driven nature of the program.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
257	370	113

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The capacity of First Nations and Inuit communities to deliver community-based health promotion and disease prevention programs and services is maintained.	# of workers who completed training during the reporting year for Healthy Child Development programs (specifically Maternal Child Health). (baseline 423)	423* by March 31, 2015 (373 without BC FNHA)	384 (without BC FNHA)
	# of workers who completed training for healthy living programs (specifically Aboriginal Diabetes Initiatives - Community Diabetes Prevention Workers). (baseline 455)	455 by March 31, 2015	494
	% of addictions counsellors in treatment centres who are certified workers.	77** by March 31, 2015	77

* Baseline was established with BC Region data. Now that FNHA is responsible for the delivery of programming in BC, including training of its workers, the revised baseline is 373.

** The target is based on historic worker certification rates and takes into account retention and attrition. In 2013-14, 77% of addictions counsellors in treatment centres were certified, up from 68% in 2010-11 (a 9% increase over three years). Refer to footnote 4 on page 83 for further context on performance measurement targets.

Performance Analysis and Lessons Learned

Training performance targets for this expected result were exceeded as training was undertaken by 384 workers for healthy childhood development programs and 494 workers for healthy living programs. The target for certification was met as 77% of addictions counsellors in treatment centres were certified workers.

In 2014-15, the First Nations Mental Wellness Continuum Framework was finalized and released. The Framework will provide guidance at all levels with respect to First Nations mental wellness to strengthen programming, and support integration and alignment with community priorities along a continuum of care.

Implementation of the Honouring Our Strengths Addictions Framework continued across the continuum of care to support strengthened community, regional, and national responses to substance use issues. In addition, a draft five-year Prescription Drug Abuse Plan was developed to ensure the reimbursement of drugs subject to abuse are consistent with their legitimate role in therapy, and aligned with clinical practice guidelines and product monographs.

The National Aboriginal Youth Suicide Prevention Strategy supported 138 youth suicide prevention projects. These projects were diverse, firmly rooted in culture, based on community priorities, and focussed on reducing risk factors among First Nations and Inuit youth. Funding for 10 Mental Wellness Teams (MWT) continued, and a community of practice gathering for these teams also occurred, which supported knowledge exchange and the sharing of best and promising practices.

The First Nations and Inuit component of the renewed FTCS (2012-17) supports First Nations and Inuit communities in implementing evidence-based tobacco control strategies. In 2014-15, resources were transferred to the British Columbia (BC) First Nations Health Authority (FNHA), and the governments of Nunavut and the Northwest Territories to enhance tobacco control strategies for First Nations and Inuit within these jurisdictions. A call for proposals was also launched, which resulted in support for 16 comprehensive projects, proposed by First Nations and Inuit to reduce smoking rates in their communities in Alberta, Saskatchewan, Manitoba, Ontario, Quebec and Atlantic Regions. A "Community of Practice" was established to support the tobacco projects, establish common performance indicators, and share best practices and available tools/services.

Health Canada is in the final stages of the development of a framework to support the prevention and management of chronic disease in First Nations communities.

Sub-Sub Program 3.1.1.1: *Healthy Child Development*

Description

The Healthy Child Development program administers contribution agreements and direct departmental spending to support culturally appropriate community-based programs, services, initiatives, and strategies related to maternal, infant, child, and family health. The range of services includes prevention and health promotion, outreach and home visiting, and early childhood development programming.

Targeted areas in the delivery of this program include: prenatal health, nutrition, early literacy and learning, and physical and children's oral health.

The program objective is to address the greater risks and lower health outcomes associated with First Nations and Inuit infants, children, and families.

This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
106,127,822	105,100,284	-1,027,538

Note: The variance between actual and planned spending is mainly due to reallocation of funding within this strategic outcome to meet program needs.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
70	112	42

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
First Nations and Inuit have access to healthy child development programs and services.	# of women accessing Prenatal and Postnatal Health, including Nutrition (specifically Canada Prenatal Nutrition Program). (baseline 7,982)	7,982 by March 31, 2015	9,971
	# of children accessing early literacy and learning (specifically Aboriginal Head Start On Reserve). (baseline 5,817)	5,817 by March 31, 2015	13,981
	# of children accessing Children's Oral Health. (baseline 18,780)	18,780 by March 31, 2015	19,865

Performance Analysis and Lessons Learned

Healthy Child Development programs, such as Maternal Child Health, Canada Prenatal Nutrition (First Nations and Inuit component), Aboriginal Head Start on Reserve, Fetal Alcohol Spectrum Disorder programs, and the Children's Oral Health Initiative, have increased access to services that support healthy outcomes. In 2014-15, the Department exceeded the target of 7,982 women accessing Prenatal and Postnatal Health, including Nutrition (specifically the Canada Prenatal Nutrition Program) by over 1,000 women. Increased access is important, as receiving healthy pregnancy and infancy services has been shown to improve health outcomes for women and infants, by reducing pregnancy complications and having healthier gestational weight gains.

In addition, 13,981 children accessed early literacy and learning through the Aboriginal Head Start on Reserve program. Opportunities for Aboriginal children to learn about their language and culture are important in supporting their connectedness to their community, which can build resiliency and promote better health. Evaluations have demonstrated that Aboriginal Head Start on Reserve has been successful in producing positive changes in children's levels of physical activity, cultural activities and reading.

Oral Health and developmental health screening are important for a child's overall health. Rates for dental surgical procedures were lower for children in communities with the Children's Oral Health Initiative when compared to those without. In addition, the oral health target of 18,780 First Nations and Inuit children accessing Children's Oral Health Initiative was exceeded by over 1,000. Communities with Maternal Child Health programming were more likely to screen for developmental milestones, prenatal risk factors and existing health conditions compared to those without.

These community-led, culturally-relevant programs and services support First Nations and Inuit children and their families in reaching their full potential. At the same time, ensuring equitable access to Healthy Child Development programs and services for communities continues to be a priority.

A 2014 Evaluation of the Healthy Living and Healthy Child Development Clusters[lvi] highlighted the need to strengthen collaboration between partners to ensure sustained partnerships and program integration. Based on these findings, Health Canada will work with other federal departments to map out current federal children and education programming for First Nations living on reserve, to support improved community planning, leveraging of existing resources and provincial partnerships, were feasible. Additionally, Health Canada is finalizing an Oral Health Strategic Action Plan as a guiding tool to strengthen partnerships and collaboration for oral health services.

Sub-Sub Program 3.1.1.2: *Mental Wellness*

Description

The Mental Wellness program administers contribution agreements and direct departmental spending that supports culturally-appropriate community-based programs, services, initiatives and strategies related to the mental wellness of First Nations and Inuit. The range of services includes prevention, early intervention, treatment, and aftercare.

Key services supporting program delivery include: substance abuse prevention and treatment (part of NADS), mental health promotion, suicide prevention, and health supports for participants of the Indian Residential Schools Settlement Agreement.

The program objective is to address the greater risks and lower health outcomes associated with the mental wellness of First Nations and Inuit individuals, families, and communities.

This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
291,117,381	298,145,199	7,027,818

Note: The variance between actual and planned spending is mainly due to additional funding received through Supplementary Estimates and a realignment from other program activities to support the prevention of prescription drug abuse and enhanced mental wellness programming. The variance is partly offset by a surplus in the Indian Residential Schools Resolution Health Support Program due to the demand driven nature of the program.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
83	128	45

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Abstinence from drug and alcohol use after addictions treatment.	% of treatment centre clients who terminated substance use of at least one substance after completing treatment.	30* by March 31, 2015	60
Reduced substance use following treatment.	% of treatment centre clients who reduced substance use of at least one substance after completing treatment.	50** by March 31, 2015	94
First Nations and Inuit have access to mental wellness programs and services.	# of projects providing suicide prevention programs (specifically National Aboriginal Youth Suicide Prevention Strategy). (baseline 115)	115 by March 31, 2015	138

* A 30% success rate after completion of treatment reflects the fact that there is a high rate of recidivism among people who seek treatment for substance abuse. Refer to footnote 4 on page 83 for further context on performance measurement targets.

** Because of the high rate of recidivism, even a reduction in at least one substance is a success. Refer to footnote 4 on page 83 for further context on performance measurement targets.

Performance Analysis and Lessons Learned

In 2014-15, 60% of treatment centre clients terminated substance use of at least one substance after completing treatment, which exceeds the 30% target. In addition, 94% of treatment centre clients reduced substance use of at least one substance after completing treatment, well exceeding the 50% target. 138 projects provided suicide prevention programs, exceeding the target of 115.

The Mental Wellness programs contributed to improving the quality and availability of comprehensive mental health and addictions services through its investments in 2014-15. Areas of focus included the reduction of substance use, certification of addictions counsellors and development of a suicide prevention project in First Nations and Inuit communities.

In 2014-15, the First Nations Mental Wellness Continuum Framework was finalized and is intended to guide communities, tribal councils, health authorities, provincial and territorial governments, and federal departments on how to adapt, optimize and realign programs and services to be more responsive and flexible in meeting the needs of First Nations peoples. A governance structure comprised of key stakeholders at the national, regional and community level was created to help guide the implementation of the First Nations Mental Wellness Continuum Framework. Work also continued with the Inuit Tapiriit Kanatami toward the development of an Inuit Mental Wellness Continuum Framework.

A community of practice was established to support 10 MWT. First Nations experts shared information on key issues related to MWTs' program and service delivery (e.g. culture as intervention), including promising practices and lessons learned. Other accomplishments that supported MWT included the finalization and dissemination of suicide prevention learning modules and funding of the First Nations Wellness/Addictions Counsellor Certification Board to provide relevant certification and training that is specific to traditional First Nations healing philosophy.

In 2014-15, Health Canada continued to support the provision of professional counselling, cultural and emotional support services to former Indian Residential School students and their families. This included investing in more than 120 First Nations and Inuit community-based organizations to make cultural and mental health support services available to eligible clients.

Addiction prevention and treatment programming was effectively delivered through a network of 44 treatment centres in the majority of First Nations and Inuit communities across Canada.

Sub-Sub Program 3.1.1.3: *Healthy Living*

Description

The Healthy Living program administers contribution agreements and direct departmental spending that supports culturally appropriate community-based programs, services, initiatives, and strategies related to chronic disease and injuries among First Nations and Inuit.

This program aims to promote healthy behaviours and supportive environments in the areas of healthy eating, physical activity, food security, chronic disease prevention, management and screening, and injury prevention policy.

Key activities supporting program delivery include: chronic disease prevention and management, injury prevention, the Nutrition North Canada–Nutrition Education Initiative, and the First Nations and Inuit component of the FTCS (being implemented in 2012-13).

The program objective is to address the greater risks and lower health outcomes associated with chronic diseases and injuries among First Nations and Inuit individuals, families, and communities.

This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
67,773,986	73,496,062	5,722,076

Note: The variance between actual and planned spending is mainly due to reallocation of funding within this strategic outcome to meet program needs.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
104	130	26

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
First Nations and Inuit have access to healthy living programs and services.	% of communities providing healthy living programs (specifically Aboriginal Diabetes Initiatives).	90 by March 31, 2015	89.1
	% of projects that deliver physical activities under the Aboriginal Diabetes Initiatives.	63* by March 31, 2015	86.1

Expected Results	Performance Indicators	Targets	Actual Results
	% of projects that deliver healthy eating activities under the Aboriginal Diabetes Initiatives.	66** by March 31, 2015	87.7

* This target reflects the fact that contribution agreement recipients will choose to deliver projects based on the needs of their communities. Refer to footnote 4 on page 83 for further context on performance measurement targets.

** This target reflects the fact that contribution agreement recipients will choose to deliver projects based on the needs of their communities. Refer to footnote 4 on page 83 for further context on performance measurement targets.

Performance Analysis and Lessons Learned

Diabetes is a significant health concern among First Nations, who experience rates of diabetes three-four times higher than the rate among non-Aboriginal Canadians. In 2014-15, Health Canada continued to invest in the Aboriginal Diabetes Initiative (ADI), which aims to reduce Type 2 diabetes through health promotion and disease prevention activities. ADI was provided in 89.1% of communities in comparison to the target of 90%, representing over 600 First Nations and Inuit communities. ADI benefits these communities by increasing awareness and knowledge of risk factors and diabetes prevention approaches, and by providing access to diabetes prevention, screening, and management services.

The types of activities supported through ADI are widely recognized as effective interventions, and the majority of provinces and territories developed similar diabetes initiatives which emphasize the importance of prevention and health promotion.

Investments in 2014-15 contributed to increased access to community-based physical activity programming and services. Examples of activities in First Nations and Inuit communities included regional-wide school-based physical activity challenges, the certification of fitness leaders, delivery of traditional and non-traditional physical activities, and healthy weight programs. Investments also contributed to enhanced access to nutrition education activities to promote healthy eating and increased access to nutritious foods.

Under the ADI, 87.7% of communities delivered healthy eating activities, and 86.1% delivered physical activity projects. These results significantly exceeded their respective targets of 66% and 63%. The presence of regional multidisciplinary teams (which included nutrition and physical activity expertise) helped promote healthy eating and physical activity at the community-level through skills and capacity development. The community health planning process also supported the creation of community linkages and partnerships with other program areas and outside partners. Through Nutrition North Canada, Health Canada provided additional supports for community-based nutrition education in 78 isolated northern First Nations and Inuit communities. Notwithstanding gains made, factors such as poverty and food insecurity continue to challenge the adoption of healthy lifestyles and improved health outcomes.

A recent evaluation (2014) of the Healthy Living and Healthy Child Development Clusters reported that the Healthy Living program has made considerable progress toward promoting healthy behaviours in First Nations and Inuit communities. However, the evaluation also highlighted the need to sustain efforts to improve access and quality of programs and services.

Health Canada has undertaken an initiative to implement accreditation and service delivery standards to support improvements in quality and access, and will develop standards specific to healthy living programming.

Sub-Program 3.1.2: *First Nations and Inuit Public Health Protection*

Description

The First Nations and Inuit Public Health Protection program delivers public health protection services to First Nations and Inuit in Canada. In the delivery of this program, the key areas of focus are communicable disease control and management, and environmental public health.

The First Nations and Inuit Public Health Protection program administers contribution agreements and direct departmental spending to support initiatives related to communicable disease control and environmental public health service delivery including public health surveillance, research, and risk analysis. Communicable disease control and environmental public health services are targeted to on-reserve First Nations, with some support provided in specific instances, (e.g., to address tuberculosis), in Inuit communities south of the 60th parallel. Environmental public health research, surveillance, and risk analysis are directed to on-reserve First Nations, and in some cases, (e.g., climate change and health adaptation, and biomonitoring), also to Inuit and First Nations living north of the 60th parallel.

Surveillance data underpins these public health activities and all are conducted with the understanding that social determinants play a crucial role. To mitigate impacts from factors beyond the public health system, the program works with First Nations, Inuit, and other organizations.

The program objective is to address human health risks for First Nations and Inuit communities associated with communicable diseases and exposure to hazards within the natural and built environments by increasing community capacity to respond to these risks.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
124,826,210	93,369,151	-31,457,059

Note: The variance between actual and planned spending is mainly due to a reallocation of funding to sub-program First Nations and Inuit Primary Care to ensure continuity of access of nursing services in remote and isolated First Nations communities.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
255	344	89

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The community capacity to respond to health emergencies is improved.	% of First Nations communities with integrated Pandemic Preparedness/Response Plans and Emergency Preparedness/Readiness Plans.	75* by March 31, 2015	81
Environmental health risks relating to water quality are reduced.	% of on-reserve public water systems that met weekly national testing guidelines for bacteriological parameters (e.g. based on testing frequency recommended in the Guidelines for Canadian Drinking Water Quality).	50.6** by March 31, 2016	42
	% of First Nations communities that have access to a trained Community-based Drinking Water Quality Monitor or an Environmental Health Officer to monitor their drinking water quality.	100 by March 31, 2016	100

* Refer to footnote 4 on page 83 for further context on performance measurement targets.

** The target of 50.6% represents a 15% improvement over the 2010 levels of 44%. It should be noted that First Nations undertake this monitoring and Health Canada provides assistance. Refer to footnote 4 on page 83 for further context on performance measurement targets.

Performance Analysis and Lessons Learned

The target for the first expected result was exceeded as there were 81% of First Nations communities with integrated Pandemic Preparedness/Response Plans and Emergency Preparedness/Readiness Plans.

In 2014-15, Health Canada supported public health measures to prevent and control cases and outbreaks of communicable diseases on-reserve; promoted public education and awareness to encourage healthy practices; strengthened community capacity; undertook monitoring, surveillance and reporting of communicable disease; and, provided a liaison and coordination function for all-hazard emergency management. For example, Health Canada and the Assembly of First Nations launched a partner engagement process to solicit the participation of a broad range of partners in the development of the Sexually Transmitted and Blood Borne Infections (STBBI) Framework. A partner engagement questionnaire was developed and distributed to assess successes, gaps and challenges in STBBI programming.

A Tuberculosis Monitoring and Performance Framework was developed to provide guidance for an enhanced approach to the monitoring of communities experiencing outbreaks or ongoing high incidence of tuberculosis. As well, an educational tool entitled *Talking Tuberculosis: An Educational Resource* was developed to assist community health professionals in raising awareness and educating community members about tuberculosis.

Health Canada continued to fund 16 community-based research and assessment projects that enable northern First Nations and Inuit communities to develop climate change adaptation strategies and action plans.

Health Canada assists First Nations communities in establishing drinking water quality monitoring programs, and has established a target of 50.6% on-reserve public water systems that are tested four times per month or 48 times in a year, in accordance with the national testing guidelines for monitoring frequency. In 2014-15, this target was not attained, as only 42% of on-reserve public water systems met this recommended frequency. However, this indicator only captures the percentage of communities that met the standard, and does not provide a global picture of the monitoring frequency of all on-reserve public water systems. The average monitoring frequency of all on-reserve public water systems was 38 weeks out of the recommended 48 weeks (or 79%) in 2014-15. Although there has been progress, compliance with monitoring frequency as outlined in the Guidelines for Canadian Drinking Water Quality continues to present logistical challenges associated with the management of very small water systems located in rural or remote locations.

Health Canada did enhanced the capacity of First Nations communities to monitor drinking water quality by providing ongoing access to a trained community-based Water Monitor or Environmental Health Officer in 100% of First Nation communities, in accordance with the established target.

Sub-Sub Program 3.1.2.1: *Communicable Disease Control and Management*

Description

The Communicable Disease Control and Management program administers contribution agreements and direct departmental spending to support initiatives related to vaccine preventable diseases, blood borne diseases and sexually transmitted infections, respiratory infections, and communicable disease emergencies. In collaboration with other jurisdictions communicable disease control and management activities are targeted to on-reserve First Nations, with support provided to specific instances, (such as to address tuberculosis), in Inuit communities south of the 60th parallel. Communicable Disease Control and Management activities are founded on public health surveillance and evidence-based approaches and reflective of the fact that all provincial and territorial governments have public health legislation.

Key activities supporting program delivery include: prevention, treatment and control of cases and outbreaks of communicable diseases; and, public education and awareness to encourage healthy practices.

A number of these activities are closely linked with those undertaken in the Environmental Health program (3.1.2.2), as they relate to waterborne, foodborne and zoonotic infectious diseases.

The program objective is to reduce the incidence, spread, and human health effects of communicable diseases for First Nations and Inuit communities.

This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
65,181,696	58,206,797	-6,974,899

Note: The variance between actual and planned spending is mainly due to reallocation of funding within this strategic outcome to meet program needs.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
123	194	71

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Improved rates of treatment adherence.	% of patients diagnosed with active tuberculosis who complete treatment.	90 by March 31, 2016	92.1
Public awareness and knowledge of vaccine preventable diseases and immunization is improved.	% of on-reserve caregivers who recognize the importance of childhood vaccination.	85* by March 31, 2016	93
	% of health care providers servicing communities who are	70** by March 31, 2016	94

Expected Results	Performance Indicators	Targets	Actual Results
	using First Nations and Inuit Health Branch (Health Canada) immunization education and awareness materials.		

* An increase of 100% was not assessed to be feasible based on other factors which can influence caregivers' perception. This was informed by a 2011 preliminary survey which found that the majority of First Nations (82%) and Inuit (75%) indicated that it was very important that all children be vaccinated. Refer to footnote 4 on page 83 for further context on performance measurement targets.

** Refer to footnote 4 on page 83 for further context on performance measurement targets.

Performance Analysis and Lessons Learned

In 2014-15, the rate of adherence target was exceeded, as 92.1% of patients diagnosed with active tuberculosis completed treatment. Targets to increase awareness among health care providers and caregivers of the importance of immunization were also exceeded. For example, 93% of on-reserve caregivers recognized the importance of childhood vaccination (target 85%) and 94% of health care providers serving First Nations and Inuit communities use Health Canada immunization education and awareness materials (target 70%).

A recent evaluation (2014) of the Communicable Disease Control and Management Programs[lvii] and services for First Nations and Inuit communities noted progress toward increasing uptake of communicable disease prevention and control measures as well as improving public awareness and knowledge of communicable diseases. The evaluation recommended that Health Canada continue efforts to ensure consistency in training and support for community health staff to continue to build community capacity and strengthen the program's ability to address diverse community-needs.

In 2014-15, Health Canada undertook two key initiatives to build community capacity. To enhance the integration of Pandemic and Emergency Preparedness Plans, Health Canada developed a communicable disease plan improvement cycle guidance document which delineates national, regional, and community activities in plan development, and in strengthening and testing processes. These plans were shared with First Nations communities as a public health tool to be used in nursing stations and health centres.

In 2014-15, Health Canada worked closely with partners to prepare for a potential case of Ebola presenting in a First Nations community. This included the development and implementation of a comprehensive train-the-trainer approach, procurement of enhanced personal protective equipment and training of 988 frontline health care professionals on its proper use across six Health Canada regions, and the BC FNHA.

Sub-Sub Program 3.1.2.2: *Environmental Public Health*

Description

The Environmental Public Health program administers contribution agreements and direct departmental spending for environmental public health service delivery. Environmental public health services are directed to First Nations communities south of the 60th parallel and address areas such as: drinking water; wastewater; solid waste disposal; food safety; health and housing; facilities inspections; environmental public health aspects of emergency preparedness response; and, communicable disease control. Environmental public health surveillance and risk analysis programming is directed to First Nations communities south of the 60th parallel, and in some cases, also to Inuit and First Nations north of the 60th parallel. It includes community-based and participatory research on trends and impacts of environmental factors such as chemical contaminants and climate change on the determinants of health (e.g., biophysical, social, cultural, and spiritual).

Key activities supporting program delivery include: public health; surveillance, monitoring and assessments; public education; training; and, community capacity building.

The program objective is to identify, address, and/or prevent human health risks to First Nations and Inuit communities associated with exposure to hazards within the natural and built environments.

This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
59,644,514	35,162,354	-24,482,160

Note: The variance between actual and planned spending is mainly due to the reallocation of funding to sub-sub program Clinical and Client Care to ensure continuity of access of nursing services in remote and isolated First Nations communities, partly offset by additional funding received through Supplementary Estimates to support the delivery of the First Nations Water and Wastewater Action Plan.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
132	150	18

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Body of community-based participatory research on environmental health hazards in First Nations and Inuit communities.	# of community-based/participatory research reports on environmental health hazards that are available. (baseline 18)	25 by March 31, 2016	26

Performance Analysis and Lessons Learned

The target for the expected result was exceeded as 26 community-based/participatory research reports on environmental health hazards were available (as compared to the target of 25 reports).

In 2014-15, Health Canada supported the development of regulations under the *Safe Drinking Water for First Nations Act*[lviii]. This included the development and launch of a consultation and engagement strategy in collaboration with Aboriginal Affairs and Northern Development Canada (AANDC) to solicit feedback on existing regulations from First Nations partners, and to share knowledge on drinking and wastewater regulations.

Health Canada produced a video on mould in collaboration with the Canada Mortgage and Housing Corporation for contractors and building maintenance staff in communities. The video was shared with First Nations community leaders and provided education and awareness on the causes of mould in buildings, where to look for root causes, and how to prevent and treat.

Health Canada continued to support community-based projects to monitor exposure to environmental hazards and the impacts of climate change. A child biomonitoring health survey pilot study for children 3-19 years was established with the Centre Hospitalier Universitaire du Québec – Université Laval. In addition, the First Nations Food, Nutrition and Environment Study released its 2011-12 report for Ontario. These results have helped strengthen evidence-based decision-making and will be used to target food security and nutrition intervention activities in FNIHB's community programs and to plan further environmental studies in the most affected First Nation populations.

Sub-Program 3.1.3: *First Nations and Inuit Primary Care*

Description

The First Nations and Inuit Primary Care program administers contribution agreements and direct departmental spending. These funds are used to support the staffing and operation of nursing stations on-reserve, dental therapy services and home and community care programs in First Nation and Inuit communities, and on-reserve hospitals in Manitoba, where services are not provided by provincial/territorial health systems. Care is delivered by a collaborative health care team, predominantly nurse-led, providing integrated and accessible health care services that include: assessment; diagnostic; curative; case-management; rehabilitative; supportive; respite; and, palliative/end-of-life care.

Key activities supporting program delivery include Clinical and Client Care in addition to Home and Community Care.

The program objective is to provide primary care services to First Nations and Inuit communities.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
263,857,153	300,663,320	36,806,167

Note: The variance between actual and planned spending is mainly due to reallocation of funding from sub-program First Nations and Inuit Public Health Protection to ensure continuity of access of nursing services in remote and isolated First Nations communities.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
569	647	78

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Primary care services based on assessed need are provided to First Nations and Inuit communities.	Utilisation rate per 1,000 eligible on-reserve population (home and community care and clinical and client care).	365.8 by March 31, 2015	365.8
Coordinated responses to primary care services.	% of First Nations communities with collaborative service delivery arrangements with external primary care service providers.	50* by March 31, 2015	57

* Refer to footnote 4 on page 83 for further context on performance measurement targets.

Performance Analysis and Lessons Learned

In 2014-15, Health Canada met its target of the 365.8 utilization rate per 1,000 of the eligible on-reserve population for home and community care and clinical and client care. Additionally, the arget for coordinated responses was exceeded as 57% of First Nations communities had ollaborative service delivery arrangements with external primary care service providers.

ealth Canada continued with the implementation of a multi-faceted nurse recruitment and etention strategy for remote and isolated First Nation communities. For example, in 2014-15, taffing tools and mechanisms were streamlined, including the design and implementation of a ast and efficient recruitment process with continuous intake of applications received online via ne "Apply Now!" interactive tool. In addition, a Relief Nursing Coordination Unit was stablished to alleviate pressure on regions and introduce standardization. The unit is managing ational nursing relief service contracts in three regions: Manitoba, Ontario and Quebec.

fforts began in 2014-15 to develop an accreditation strategy to address the challenges to ncreasing the number health facilities entering the accreditation process.

ollaborative initiatives have taken place to support linkages between Health Canada, provincial ervices, organisations and regulatory bodies. For example, Health Canada worked with colleges nd universities on access to nursing program offerings as well as the recruitment of nurses. ctivities to strengthen collaboration and improve information sharing and partnerships are ngoing.

ub-Sub Program 3.1.3.1: *Clinical and Client Care*

escription

he Clinical and Client Care program is delivered by a collaborative health care team, redominantly nurse-led, providing integrated and accessible health and oral health care services at include assessment, diagnostic, curative, and rehabilitative services for urgent and nonrgent care.

ey services supporting program delivery include: triage, emergency resuscitation and abilization, emergency ambulatory care, and out-patient non-urgent services; coordinated and tegrated care and referral to appropriate provincial secondary and tertiary levels of care outside e community; and, in some communities, physician visits and hospital in-patient, ambulatory, d emergency services.

ne program objective is to provide clinical and client care services to First Nations individuals, milies, and communities.

nis program uses funding from the following transfer payment: First Nations and Inuit Primary ealth Care.

ary Financial Resources (dollars)

5 d Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
,936	191,477,026	33,362,090

variance between actual and planned spending is mainly due to reallocations of funding from Sub-sub program ntal Public Health to ensure continuity of access of nursing services in remote and isolated First Nations communities.

Resources (FTEs)

d	2014-15 Actual	2014-15 Difference (actual minus planned)
	586	59

variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

ance Results

d Results	Performance Indicators	Targets	Actual Results
ions and Inuit ons have o clinical and re services.	% of eligible on-reserve population accessing clinical and client care services.	29* by March 31, 2015	43.8
	% of urgent Clinical and Client Care services provided in nursing stations.	30 by March 31, 2015	11.1
delivery nents with delivery are provided lations and munities.	% of referrals to emergency/hospital care.	28 by March 31, 2015	See note**

is based on service utilization and maintaining service levels for those in need. It is not anticipated that the entire eserve population will need to use clinical and client care services.

ent information is available for the reporting period. The performance indicator will be re-assessed for next fiscal

ance Analysis and Lessons Learned

anada's performance on clinical and client care services is focussed on those ties in Alberta, Manitoba, Ontario, and Quebec regions where Health Canada directly Clinical and Client program services. Health Canada exceeded the target as 43.8% of the n-reserve population accessed clinical and client care services. Based on data s, communities from Manitoba were not included in this result.

urgent clinical and client services were provided in nursing stations, a shortfall from ed 30%. The gap may be partially explained by data limitations, as data for the entire r was not available for Ontario. Based on lessons learned from data collection

a new Nursing Station Report Template has been developed to collect more complete
re years.

ada funded or delivered primary care services, including 24/7 access to emergency
80 remote and isolated First Nations communities, where access to provincial or
ealth care services is limited. Health Canada funded another nine communities
B.C. FNHA.

ization of the CPGs was initiated, including the establishment of a contract to update
e in the CPGs and to develop supporting tools. To support this work, an Advisory
was created to provide expertise and guidance.

ada adapted education materials for the prevention of antimicrobial resistance (AMR)
ted them to nursing stations to promote appropriate use of antibiotics and prevent
ine resources on AMR were also made available for practitioners.

o Program 3.1.3.2: *Home and Community Care*

nd Community Care program administers contribution agreements with First Nation
mmunities and territorial governments to enable First Nations and Inuit individuals
ties, chronic or acute illnesses, and the elderly to receive the care they need in their
ommunities. Care is delivered primarily by home care registered nurses and trained
sonal care workers.

ry of this program First Nations and Inuit Health Branch provides funding through
agreements and direct departmental spending for a continuum of basic essential
n as: client assessment and case management; home care nursing, personal care and
rt as well as in-home respite; and, linkages and referral, as needed, to other health
rvices. Based on community needs and priorities, existing infrastructure, and
of resources, the Home and Community Care program may be expanded to include
ervices. These services may include: rehabilitation and other therapies; adult day
eal programs; in-home mental health; in-home palliative care; and, specialized
otion, wellness, and fitness services.

objective is to provide home and community care services to First Nations and
uals, families, and communities.

n uses funding from the following transfer payment: First Nations and Inuit Primary

Bu

20
Pl

10

Not
mee

Hu

20
Pl

42

Note

Per

Ex

Ho
ca
pro
Na
co

Se
arr
int
del
pro
Na
co

* Ref

Per

The
1,00
prov
exce
serv

Duri
hour
final
dem
hom
Nati

ry Financial Resources (dollars)

Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
217	109,186,294	3,444,077

riance between actual and planned spending is mainly due to reallocation of funding within this strategic outcome to n needs.

Resources (FTEs)

	2014-15 Actual	2014-15 Difference (actual minus planned)
	61	19

riance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

ance Results

l Results	Performance Indicators	Targets	Actual Results
d community ices are in First nd Inuit ies.	Utilisation rate per 1,000 on-reserve population.	71.2 by March 31, 2015	71.2
	% distribution of Home and Community Care hours of care provided for home care nursing.	8.6 by March 31, 2015	8.6
elivery ents with nd external artners are n First nd Inuit ies.	% of communities with collaborative service delivery arrangements with external service delivery partners.	50* by March 31, 2015	57

otnote 4 on page 83 for further context on performance measurement targets.

ance Analysis and Lessons Learned

s for home and community care services were met, as the utilisation rate was 71.2 per eserve population and the distribution of Home and Community Care hours of care or home care nursing was 8.6%. The service delivery arrangement target was as 57% of communities had collaborative service delivery arrangements with external livery partners, in comparison to the target of 50%.

14-15, the First Nations Home and Community Care program provided 1.8 million are in 500 First Nation and Inuit communities. Additionally, a 10-year Plan was o assist program staff, at all levels, to anticipate and respond to emerging health and hic trends, complex and changing health needs, and other challenges related to the needs of First Nations and Inuit clients. The Plan reflects the priorities of First d Inuit and takes into consideration the trends and projections of home care in Canada

e health care continuum. Each goal is client-focused and supports health providers in
n of exemplary care that considers the assessed needs of the client as he/she
rough the experience of illness and loss. The plan is expected to be a key resource
ble program officials, home care staff and communities to adequately respond to
enges in a strategic and integrated fashion over the next 10 years.

3.2: *Supplementary Health Benefits for First Nations and*

upplementary Health Benefits for First Nations and Inuit program, the Non-Insured
fits (NIHB) Program provides registered First Nations and recognized Inuit residents
ith a specified range of medically necessary health-related goods and services, which
rwise provided to eligible clients through other private or provincial/territorial
IHB include: pharmaceuticals; medical supplies and equipment; dental care; vision
erm crisis intervention mental health counselling; and, medical transportation to
cally required health services not available on-reserve or in the community of
he NIHB Program also pays health premiums on behalf of eligible clients in BC (as
, NIHB will no longer pay premiums for First Nations residents of BC, who will
nts of the FNHA in accordance with the BC Tripartite Health Agreement and sub-

delivered through registered, private sector health benefits providers (e.g.,
and dentists) and funded through NIHB's electronic claims processing system or
onal offices. Some benefits are also delivered via contribution agreements with First
Inuit organizations and the territorial governments in Nunavut and Northwest

objective is to provide NIHB to First Nations and Inuit people in a manner that
o improvements in their health status to be comparable to that of the Canadian

uses funding from the following transfer payment: First Nations and Inuit
ry Health Benefits.

ncial Resources (dollars)

	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
	1,133,324,859	1,104,008,776	1,075,694,038	-57,630,821

57.6 million between actual and planned spending is mainly due to the following:

.3 million between planned spending and total authorities is mainly due to a reallocation of funding egic outcome relating to the creation of restricted funding for NIHB.

.3 million between total authorities and actual spending is mainly due to funding held frozen, and a he demand driven nature of the program.

ces (Full-Time Equivalents [FTEs])

	2014-15 Actual	2014-15 Difference (actual minus planned)
	449	-42

TE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

sults

	Performance Indicators	Targets	Actual Results
nuit HB.	% of eligible First Nations and Inuit population who accessed at least one NIHB.	72* by March 31, 2015	71.2

service utilization and maintaining service levels for those in need. It is not anticipated that the entire need to use non-insured health benefits.

alysis and Lessons Learned

le First Nations and Inuit population accessed at least one NIHB in target of 72%. The actual results are in line with expectations given the ure of NIHB and that the variance is less than one percent. Health Canada NIHB for over 824,000 eligible First Nations people and Inuit.

Canada developed an interim five-year management plan for Supplementary hese efforts are focussed on addressing goals such as client health and safety, amlined access to benefits, reduced administrative costs and improved

s prescription drug abuse strategy and client safety were enhanced through the veillance of prescription drug utilization and prescribing patterns, including sids and other drugs of concern, delisting of medications at risk for abuse that gnificant therapeutic role, and increased access to drugs with less abuse who need them. To support this function, work began on the development of a

---

Sub-
year
sugge

A nat
Scho
proce
Guid
enrol

Other
in the
imple
Healt
provi

Prog
Inui

Descr

The *D*
for the
contri
progra

The pr
health
indivi
and se
First N
provin

The pr
becom

Budge

2014-1 Main
604,17

Note: Th
other pro
infrastruc

iption Drug Abuse Monitoring System. Program data showed a continued
ne in the number of clients identified as engaging in patterns of use that
escription drug misuse.

ealth counsellor enrollment process for the NIHB and Indian Residential
Health Support Program was implemented. In support of the enrolment
oint NIHB/Indian Residential Schools Resolution Health Support Program
alth Counselling was finalized and posted on the internet, and the provider
been updated to include a section on cultural competency.

2014-15 included the provision of claims processing and associated services
dical supplies and equipment, and dental benefits areas to support the
he *BC Tripartite Framework Agreement on First Nation Health Governance*
his role, NIHB acted as a claims adjudicator and claims processing service
NHA as a transitional measure for these benefits.

Health Infrastructure Support for First Nations and

Health Act (1996), and the *Indian Health Policy* (1979) provide the authority
ructure Support for First Nations and Inuit program to administer
ents and direct departmental spending to support the delivery of health
es.

es First Nation and Inuit capacity to design, manage, deliver, and evaluate
services. To better meet the unique health needs of First Nations and Inuit
and communities this program also supports: innovation in health program
health governance partnerships between Health Canada, the provinces, and
vincial health services; and, improved integration of First Nation and
vices.

ve is to help improve the health status of First Nations and Inuit people, to
o that of the Canadian population over the long-term.

al Resources (dollars)

014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
04,177,779	640,557,440	640,190,204	36,012,425

million between actual and planned spending is mainly due to the reallocations of funding from
epartment in order to make essential and priority capital investments in First Nations and Inuit

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
125	190	65

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. Health Canada receives annual growth of 3% on a portion of First Nations and Inuit Primary Health Care programs. These funds are appropriated as Operating funds. Consistent with program authorities approved by Treasury Board, Health Canada has annually realigned resources based on program needs from Operating to Salaries over the past several years; therefore, Actual FTE Utilization is higher than Planned. The Department plans to make adjustments in future Main Estimates to reflect current business requirements now that DPRs are reporting at the Sub-sub Program levels.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Innovative and integrated health governance relationships are increased.	% of provincial and territorial with multi-jurisdictional agreements to jointly plan, deliver and/or fund integrated health services for aboriginal Canadians.	100 by March 31, 2015	100
The capacity of First Nations and Inuit to influence and/or control (design, deliver, and manage) health programs and services is improved.	# of communities that have Flexible or Block funding agreements (i.e. communities that design, deliver and manage their health programs and services). (baseline 300)	310 by March 31, 2016	331

Performance Analysis and Lessons Learned

Health Canada met the target of 100% of provinces and territories with multi-jurisdictional agreements to jointly plan, deliver and/or fund integrated health services for aboriginal Canadians. The target for the second expected result was exceeded as there were 331 communities that had Flexible or Block funding agreements, which allowed communities to design, deliver and manage their health programs and services, compared to the target of 310 communities.

In 2014-15, Health Canada fully implemented AANDC's risk management tool (the General Assessment) using the Grants and Contributions Information Management System (GCIMS). A common approach to default management using the Default Prevention and Management Policy and associated suite of tools has been in place since 2013. In 2014-15, internal processes for conducting joint assessments (for both risk and default management) and the protocol for routing/approvals between departments were enhanced based on specific regional structures within Health Canada and AANDC. These changes allowed for greater efficiencies and collaboration between departments for common recipients.

A key challenge faced when conducting joint assessments for common Health Canada/AANDC recipients was overcoming programmatic differences between each department. Notwithstanding these challenges, a single federal standardized financial reporting protocol was implemented to avoid duplication and reduce the administrative burden for recipients. Health Canada will continue to work with AANDC to further align policies and processes.

Following the transfer of the management and delivery of health programming to the First Nations Health Authority of BC, Health Canada has continued as a funder and a governance partner, supporting the integration and accountability processes.

Health Canada funded collaborative efforts with provinces for the expansion of eHealth technology to increase the overall effectiveness of the provision of services on reserves. FNIHB added 19 new telehealth sites in First Nations communities and worked with First Nations and provinces to leverage provincially interoperable Electronic Health Records (EMR) within communities. Health Canada supported First Nations communities in their efforts to engage with the provincial deployment of Panorama or provincially selected public health information systems.

Sub-Program 3.3.1: *First Nations and Inuit Health System Capacity*

Description

The First Nations and Inuit Health System Capacity program administers contribution agreements and direct departmental spending focussing on the overall management and implementation of health programs and services.

This program supports the promotion of First Nations and Inuit participation in: health careers including education bursaries and scholarships; the development of, and access to health research; information and knowledge to inform all aspects of health programs and services; and, the construction and maintenance of health facilities. This program also supports efforts to develop new health governance structures with increased First Nations participation.

Program engagement includes a diverse group of partners, stakeholders, and clients including: First Nations and Inuit communities, district and tribal councils; national Aboriginal organizations and non-governmental organizations; health organizations; provincial and regional health departments and authorities; post-secondary educational institutions and associations; and, health professionals and program administrators.

The program objective is to improve the delivery of health programs and services to First Nations and Inuit by enhancing First Nations and Inuit capacity to plan and manage their programs and infrastructure.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
165,357,063	200,479,653	35,122,590

Note: The variance between actual and planned spending is mainly due to the reallocations of funding from other programs within the Department.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
68	100	32

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Quality in the delivery of programs and services is improved.	# of communities accessing accredited health services. (baseline 59)	77 by March 31, 2015	126
Health facilities managed by First Nations and Inuit are safe.	% of health facilities subject to an Integrated Facility Audit that do not have critical property issues. (baseline 55)	58* by March 31, 2015	79

* This target represents an increase of 5% from the previous measure. Baseline information on the percentage of critical property issues noted during previous Integrated Facility Audits was used to establish the target of 58%.

Performance Analysis and Lessons Learned

The target for the first expected result was exceeded as 126 communities were accessing accredited health services in 2014-15, in comparison to the target of 77 communities. The target for safe health facilities was exceeded as 79% of the 24 health facilities that were subject to an Integrated Facility Audit did not have critical property issues, in comparison to the target of 58%.

In 2014-15, Health Canada held discussions with AANDC to collaborate on facilities inspections and to explore potential joint projects whereby efficiencies (and by extension, cost savings) could be realized.

The health facilities Long Term Capital Plan (LTCP) links program operating requirements, including current and future needs and risks, with specific capital project proposals. Health

Canada used the LTCP as a tool to identify, assess, and prioritize capital projects for approval and implementation. In 2014-15, seven major multi-year projects and over 100 minor projects identified on the LTCP were funded.

In 2014-15, the regional LTCP planning cycle was synchronized with the new Health Canada-wide planning cycles and allowed for the capital planning to be fully integrated with other program planning processes. This improved efficiencies and provided clearer and timelier communication to First Nations partners.

Health Canada continued to strengthen collaboration with AANDC for a comprehensive community development approach, based on the joint Community Development Framework. Over 400 participants completed the associated training in 15 sessions over the 2014-15, with a strong emphasis on collaboration between organizations and with Aboriginal communities. Participants attended from Health Canada, AANDC, PHAC and other federal departments, as well as provincial health authorities.

Situational assessments with the regions were completed to inform the continued development of a surveillance and information framework that is aligned with First Nations/Inuit/provincial/ territorial surveillance strategies and relevant at the community and regional levels.

Sub-Sub Program 3.3.1.1: *Health Planning and Quality Management*

Description

The Health Planning and Quality Management program administers contribution agreements and direct departmental spending to support capacity development for First Nations and Inuit communities.

Key services supporting program delivery include: the development and delivery of health programs and services through program planning and management; on-going health system improvement via accreditation; the evaluation of health programs; and, support for community development activities.

The program objective is to increase the capacity of First Nations and Inuit to design, manage, evaluate, and deliver health programs and services.

This program uses funding from the following transfer payment: First Nations and Inuit Health Infrastructure Support.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
123,314,951	113,232,689	-10,082,262

Note: The variance between actual and planned spending is mainly due to a realignment of resources from plans in order to meet program needs.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
36	60	24

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The capacity to deliver health programs and services is increased.	# of organisations that provide accredited community health services. (baseline 35)	53 by March 31, 2015	60

Performance Analysis and Lessons Learned

Accreditation is a nationally and internationally recognized process that ensures a standardized level of quality in health planning, management and delivery of health services. By evaluating the quality of care and services they provide, and comparing against national standards of excellence, organizations are able to evaluate their clinical and operational performance. This provides them with a clear picture of their strengths and areas to be improved.

In 2014-15, Health Canada increased the number of community health centres in the accreditation process from 87 to 91, and increased the number of communities that receive primary health care services from fully accredited health centres to 126. In addition to the 60 accredited organizations, there are currently 45 addictions treatment centres and 1 nursing station in the accreditation process.

Health Canada continued to implement the Quality Improvement Framework by focussing on employee training. In 2014-15, training on tools and techniques to improve the way programs and services were developed and delivered to approximately 150 employees.

Sub-Sub Program 3.3.1.2: *Health Human Resources*

Description

The Health Human Resources program administers contribution agreements and direct departmental spending to promote and support competent health services at the community level by increasing the number of First Nations and Inuit individuals entering into and working in health careers and ensuring that community-based workers have skills and certification comparable to workers in the provincial/territorial health care system. This program engages many stakeholders, including: federal, provincial and territorial governments and health professional organizations; national Aboriginal organizations; non-governmental organizations and associations; and, educational institutions.

Key activities supporting program delivery include: health education bursaries and scholarships; health career promotion activities; internship and summer student work opportunities; knowledge translation activities; training for community based health care workers and health managers; and, development and implementation of health human resources planning for Aboriginal, federal, provincial, territorial, health professional associations, educational institutions, and other stakeholders.

The program objective is to increase the number of qualified First Nations and Inuit individuals working in health care delivery.

This program uses funding from the following transfer payment: First Nations and Inuit Health Infrastructure Support.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
9,725,427	7,586,800	-2,138,627

Note: The variance between actual and planned spending is mainly due to reallocation of funding within this strategic outcome to meet program needs.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
25	11	-14

Note: The variance in FTE utilization is mainly due to savings achieved from simplifying and streamlining operations while maintaining services to Canadians.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Greater participation of Aboriginal people in post-secondary education leading to health careers.	# of bursaries and scholarships provided to Aboriginal people per year. (baseline 340)	425 by March 31, 2015	882

Performance Analysis and Lessons Learned

n 2014-15, the Aboriginal Health Human Resources Initiative (AHHRI) continued to increase he Aboriginal health workforce through 882 bursaries and scholarships awarded to health career tudents through a continued partnership with Indspire, an Indigenous-led Canadian registered harity. Exceeding the target of 425 bursaries and scholarships, Health Canada's investments upported students in health professions such as nursing and medicine, midwifery, hysiotherapy, pharmacy, laboratory technology, and radiation technology. Additionally, AHHRI supported post-secondary educational support programs to colleges and universities, ncluding bridging or access to post-secondary health programs, curriculum adaptation, nentoring, tutoring, exam assistance, and projects to enhance the cultural competency of future ealth care providers.

he AHHRI also supported the First Nations Health Managers Association to provide training or First Nations community health managers, to improve the quality and management of health ervices in First Nations communities. In addition, AHHRI supported training for community-ased workers.

Sub-Sub Program 3.3.1.3: *Health Facilities*

Description

he Health Facilities program administers contribution agreements and direct departmental pending that provide communities and/or health care providers with the facilities required to afely and efficiently deliver health programs and services. Direct departmental spending ddresses the working conditions of Health Canada staff engaged in the direct delivery of health rograms and services to First Nations and Inuit.

ey activities supporting program delivery include: investment in infrastructure that can include e construction, acquisition, leasing, operation, maintenance, expansion and/or renovation of ealth facilities and security services; preventative and corrective measures relating to nfrastructure; and, improving the working conditions for Health Canada staff so as to maintain r restore compliance with building codes, environmental legislation, and occupational health nd safety standards.

gram objective is to support the development and delivery of health programs and through investments in infrastructure.

gram uses funding from the following transfer payment: First Nations and Inuit Health cture Support.

ary Financial Resources (dollars)

d Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
685	79,660,164	47,343,479

ariance between actual and planned spending is mainly due to the reallocations of funding from other programs Department in order to make essential and priority capital investments in First Nations and Inuit infrastructure.

Resources (FTEs)

	2014-15 Actual	2014-15 Difference (actual minus planned)
	29	22

ariance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

ance Results

d Results	Performance Indicators	Targets	Actual Results
cilities that program are safe.	% of "high priority" recommendations stemming from Integrated Facility Audits are addressed on schedule. (baseline 23)	50* by March 31, 2015	51
rograms and are supported effective ity capacity to their health	# of recipients that have signed contribution agreements that start in 2011-12 or later that have developed plans for managing the operations and maintenance of their Health Infrastructure. (baseline 2)	15 by March 31, 2015	45

nada works toward improving its collaborative process with First Nations communities to address facility The baseline of 23% was set in 2012-13, and the target of 50% is set to be achieved by March 31, 2016. Refer to n page 83 for further context on performance measurement targets.

e Analysis and Lessons Learned

the first expected result was exceeded as 51% of "high priority" recommendations m Integrated Facility Audits were addressed on schedule.

ealth Canada provided ongoing contributions to First Nations to support the ajor (construction) and minor (renovation and/or repair) projects related to health ructure. For major projects on the LTCP, of which most are multi-year, vas completed for four projects, one three-year construction project was initiated, construction projects were planned and designed (made shelf ready) so that nay commence as funding becomes available. In addition, more than 100 minor successfully delivered as planned and approved in the national LTCP.

continue to work through the challenges of delivering these projects, such as ther and availability of service providers. These challenges become amplified are delivered in remote and/or isolated communities. The impact of these ulted in the shifting of some project timelines, but did not inhibit the overall ery for 2014-15.

ficiencies identified in Integrated Facility Audits is important to ensure health afe for those delivering health services to First Nation members. In 2014-15, supported First Nations to address 45 deficiencies and will continue to work with o address the remaining deficiencies in a timely manner.

015, 45 recipients had operations and maintenance plans in their signed greements, exceeding the target of 15. These agreements supported the building of pacity to developed plans for managing the operations and maintenance of their ucture.

ram 3.3.2: *First Nations and Inuit Health System ation*

ons and Inuit Health System Transformation program integrates, coordinates, and ative publicly funded health systems serving First Nations and Inuit individuals, ommunities through the administration of contribution agreements and direct pending.

ncludes the development of innovative approaches to primary health care, estment in appropriate technologies that enhance health service delivery, and development of new governance structures and initiatives to increase First uit participation in, and control over, the design and delivery of health programs their communities.

h this program, Health Canada engages and works with a diverse group of partners,
lders, and clients including: First Nations and Inuit communities, tribal councils,
inal organizations, provincial and regional health departments and authorities, post-
ary educational institutions and associations, health professionals and program
strators.

gram objective is that First Nations and Inuit health systems are more effective and
t.

tary Financial Resources (dollars)

5 d Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
,557	39,444,860	-749,697

variance between actual and planned spending is mainly due to reallocation of funding within this strategic outcome to
ram needs.

n Resources (FTEs)

5 d	2014-15 Actual	2014-15 Difference (actual minus planned)
	90	33

variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

nance Results

ed Results	Performance Indicators	Targets	Actual Results
keholders in nal health are d in the ion of health s.	% of provincial and territorial advisory committees in which key stakeholders in the integration of health services (First Nations and Inuit/ provincial and territorial) are represented.	100 by March 31, 2015	100

nance Analysis and Lessons Learned

15, the target for the expected result was met as 100% of provincial and territorial
committees were represented by key stakeholders in the integration of health services,
g First Nations, Inuit, provincial and territorial representatives. For example, the Atlantic
participated in trilateral health tables in Nova Scotia, Prince Edward Island and
ndland to support better integration of services for healthy First Nations and Inuit
ities. The Keewatin Table Tripartite in Northern Ontario was established to address
orthern health issues, and the Nunavut Tripartite Health Table was set up to improve

through improved coordination and shared priority-setting. Alberta Region, in
n with Co-management, developed a joint action plan to improve the health of First
ple. Other regions continued to engage their respective Provincial or Territorial
s through a variety of mechanisms on collaborative approaches to planning and
ery.

Health Canada continued to advance its working relationships with First Nations and
zations and with provincial/territorial health systems at the national and regional
nally, an Engagement Protocol was developed by FNIHB and the Assembly of First
pport a mutually acceptable standard of engagement for FNIHB policy and program

inued efforts to streamline the administration of contribution agreements to support
h services. FNIHB collaborated with AANDC to advance implementation of
eneral Assessment tool, and regions were able to complete a risk assessment for
ngements using a single tool. A General Assessment was established for FNIHB
ngements for fiscal year 2015-16.

rts to support innovation include working with First Nations, the provinces and
here possible, to deploy telehealth services and improve access to community-level
nd services in a fully integrated fashion. Health Canada maintained current
and progress on eHealth to support and enable the delivery of modern primary and
care services to geographically remote communities, raising the quality of health
communities.

Program 3.3.2.1: *Systems Integration*

Integration program administers contribution agreements and direct departmental
etter integrate health programs and services funded by the federal government with
by provincial and territorial governments.

supports the efforts of partners in health services, including: First Nations and
ouncils, regional/district health authorities, regions, national Aboriginal
, and provincial/territorial organizations to integrate health systems, services, and
hey are more coordinated and better suited to the needs of First Nations and Inuit.
also promotes and encourages emerging tripartite agreements.

vities supporting program delivery include: development of multi-party structures to
y integration priorities and plans for further integrating health services in a given
d territorial; and, implementation of multi-year, large-scale health service
ojects consistent with agreed-upon priorities (i.e., a province-wide public health
integrated mental health services planning and delivery on a regional scale).

Th
ac
an

Th
Inf

Bu

2 P
14

Not
out

Hu

2 P
9

Not

Pe

Ex
Co fo Ab se

Pe

The
Nat
an i
and
pro
terr
dev
hun
regi

bjective is a health system that is efficient and integrated resulting in increased
nd improved health outcomes for First Nations and Inuit individuals, families,
es.

ses funding from the following transfer payment: First Nations and Inuit Health
upport.

nancial Resources (dollars)

ding	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
	17,091,667	2,467,292

etween actual and planned spending is mainly due to the reallocation of funding within this strategic
gram needs.

rces (FTEs)

	2014-15 Actual	2014-15 Difference (actual minus planned)
	27	18

n FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs.

Results

lts	Performance Indicators	Targets	Actual Results
anning ion of, n ased.	% of First Nations and Inuit communities involved in a Health Services Integration Fund project, which affirm that collaboration among the respective jurisdictions involved in planning, delivering and/or funding health services.	100 by March 31, 2015	97

Analysis and Lessons Learned

e expected result was not met as 501 out of 518 communities or 97% of First
it communities involved in a Health Services Integration Fund project, affirmed
ollaboration among the respective jurisdictions involved in planning, delivering
health services (as opposed to the goal of 100% of communities). Seventy-seven
he Health Services Integration Fund were funded across all provinces and
e projects supported First Nations and Inuit communities and organizations to
ive approaches to integrate federal and provincial/territorial health services. Five
hteen communities were involved in integration activities with 47 separate
uthorities and 18 non-governmental partners.

First I
relatio
acces
in pla

Sub

Descr

The el
spend
enable
comm
spend
comm

Key a
delive
makin

The p
Inuit i
purpo

This p
Infrast

Budge

2014- Plann
25,57

Note: Th
outcome

Huma

2014- Plann
48

Note: Th

nit at both regional and individual community levels, are building their own
ovinces (especially Regional Health Authorities), resulting in increased
care. New service agreements, protocols and models of care have been put
f Health Services Integration Fund funding.

ram 3.3.2.2: *e-Health Infostructure*

cture program administers contribution agreements and direct departmental
nd sustain the use and adoption of appropriate health technologies that
providers to better deliver health services in First Nations and Inuit
eHealth partnerships, technologies, tools, and services. Direct departmental
ts national projects that examine innovative information systems and
nologies and that have potential national implications.

ting program delivery include: public health surveillance; health services
l community care included); health reporting, planning and decision
ion/compatibility with other health service delivery partners.

e is to improve the efficiency of health care delivery to First Nations and
ilies, and communities through the use of eHealth technologies for the
collecting, communicating, managing, disseminating, and using data.

nding from the following transfer payment: First Nations and Inuit Health
t.

l Resources (dollars)

	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
	22,353,193	-3,216,989

ctual and planned spending is mainly due to the reallocation of funding within this strategic
eds.

(FTEs)

	2014-15 Actual	2014-15 Difference (actual minus planned)
	63	15

ilization is mainly due to a realignment of resources from plans in order to meet program needs.

Perform

Expecte
Access t Infostruc improve
Integrati health sy First Nat

Perform

In 2014-
informati
module w
Nations c
15 First N

In 2014-
implemen
19 new si
target of
operation
had been
obtaining
network;

Health Ca
highlight
provincia
establishi

Lessons l
moderniz
communi
clinical se
moderniz
Panorama

Work beg
advance t
initiating
to acquire

s

Performance Indicators	Targets	Actual Results
# of First Nations communities using Panorama or equivalent public health information system. (baseline 0)	24 by March 31, 2015	33
# of telehealth sites implemented. (baseline 240)	250 by March 31, 2015	218

s and Lessons Learned

tions communities were using Panorama or equivalent public health
ich exceeded the target of 24 communities. Panorama's Inventory
seven First Nations depot sites in the Saskatchewan region and 11 First
the Quebec region. Panorama's Immunization module was deployed in
nities.

lth sites were targeted to be implemented, based on the objective of
tes in addition to the existing 240 sites. This objective was exceeded as
mented in Alberta, Saskatchewan, Manitoba and Quebec. The overall
hieved, as a number of sites within the existing 240 sites were not
These sites were not included in the results. In these cases, the equipment
was not yet in use. Factors that impact operations include: delays in
pgrades, tower installation, or certification by the provincial telehealth
allenges; funding; and infrastructure issues.

ss towards the implementation of additional telehealth sites has
ce of investing the time to build effective relationships between federal,
ons partners; developing human resource capacity on reserves; and,
etwork access.

ore that sustainable broadband connectivity is the key element for
-level health services delivery (especially telehealth) in First Nations
y of connectivity is directly linked to the quality and range of telehealth
e to communities. Without broadband services, efforts to bring a
structure incorporating telehealth, public health surveillance such as the
lectronic Medical Records would not be possible.

lopment of a First Nations EMR Strategy and a National EMR Project to
addition, the multi-year EMR pilot in Manitoba region was advanced by
act assessment and a procurement process to solicit bids from vendors
ion.

Sub-Program 3.3.3: *Tripartite Health Governance*

Description

FNIHB's longer-term policy approach aims to achieve closer integration of federal and provincial health programming provided to First Nations, as well as to improve access to health programming, reduce instances of service overlap and duplication, and increase efficiency where possible.

The BC Tripartite Initiative consists of an arrangement among the Government of Canada, the Government of BC, and BC First Nations. Since 2006, the parties have negotiated and implemented a series of tripartite agreements to facilitate the implementation of health projects, as well as the development of a new First Nations health governance structure. In 2011, the federal and provincial Ministers of Health and BC First Nations signed the legally-binding BC Tripartite Framework Agreement on First Nation Health Governance.

This BC Tripartite Framework Agreement commits to the creation of a new province-wide FNHA to assume the responsibility for design, management, and delivery/funding of First Nations health programming in BC. The FNHA will be controlled by First Nations and will work with the province to coordinate health programming. It may design or redesign health programs according to its health plans. Health Canada will remain a funder and governance partner but will no longer have any role in program design/delivery.

Funding under this program is limited to the FNHA for the implementation of the BC Tripartite Framework Agreement.

The program objective is to enable the newly formed FNHA to develop and deliver quality health services that feature closer collaboration and integration with provincial health services.

This program uses funding from the following transfer payment: First Nations and Inuit Health Infrastructure Support.

Budgetary Financial Resources (dollars)

2014-15 Planned Spending	2014-15 Actual Spending	2014-15 Difference (actual minus planned)
398,626,159	400,265,691	1,639,532

Note: The variance between actual and planned spending is mainly due to additional funding transferred to the FNHA in BC to support comprehensive Health Planning activities, which is partly offset by reductions for Self-Governing First Nations in BC.

Human Resources (FTEs)

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
0	0	0

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Reciprocal accountability amongst tripartite governance partners, as stated in section 2.2 of the BC Tripartite Framework Agreement on First Nations Health Governance.	% of planned partnership and engagement activities, as committed in section 8 of the BC Tripartite Framework Agreement.	100 by March 31, 2016	100

Performance Analysis and Lessons Learned

In October 2014, Health Canada marked the one-year anniversary of the transfer of federal functions and operational responsibilities for the management and delivery of First Nations health programs and services in BC to a new FNHA.

The FNHA has successfully assumed the responsibilities for policy, planning, design and delivery of health programs and services and has initiated a gradual transformation in the way in which First Nations health programs are managed. The FNHA is working more closely with the provincial health system to improve the quality, accessibility and responsiveness of health care services through partnerships with the regional health authorities. First Nations are also in a position to incorporate their cultural knowledge, beliefs and values into the design and planning of their health programs and services.

In the post-transfer era, Health Canada's relationship with First Nations in BC has evolved. Health Canada remains a funder and a governance partner which provides support to the integration and accountability processes. Health Canada and the FNHA are also re-defining their partnership through collaborative planning and priority setting as well as exploring broader wellness approaches in health. In 2014-15, Health Canada met the target of undertaking 100% of planned partnership and engagement activities, as committed in section eight of the BC Tripartite Framework Agreement.

In 2014-15, Health Canada continued to advance its working relationships with First Nations and Inuit organizations and with provincial/territorial health systems at the national and regional levels. Nationally, an Engagement Protocol was developed by FNIHB and the Assembly of First Nations to support a mutually acceptable standard of engagement for FNIHB policy and program initiatives. Regionally, the Atlantic Region participated in trilateral health tables in Nova Scotia, Prince Edward Island and Newfoundland to support better integration of services for healthy First Nations and Inuit communities.

The Keewatin Senior Trilateral Health Table was established to address Northern Ontario health challenges, as identified by Nishnawbe Aski Nation and Grand Council Treaty#3. The Nunavut Tripartite Health Table was established to improve health outcomes of Inuit in Nunavut by facilitating strengthened coordination efforts and identifying shared priorities and opportunities for action between Nunavut Tunngavik Inc., the Government of Nunavut and Health Canada. Alberta Region, in collaboration with Co-management, developed a joint action plan to improve the health of First Nations people. Other regions continued to engage their respective Provincial or Territorial organizations through a variety of mechanisms on collaborative approaches to planning and service delivery.

Internal Services

Description

Internal Services are groups of related activities and resources that are administered to support the needs of programs and other corporate obligations of an organization. These groups are Management and Oversight Services, Communications Services, Legal Services, Human Resources Management Services, Financial Management Services, Information Management Services, Information Technology Services, Real Property Services, Materiel Services, Acquisition Services, and Travel and Other Administrative Services. Internal Services include only those activities and resources that apply across an organization and not those provided to a specific program.

Budgetary Financial Resources (dollars)

2014-15 Main Estimates	2014-15 Planned Spending	2014-15 Total Authorities Available for Use	2014-15 Actual Spending (authorities used)	2014-15 Difference (actual minus planned)
271,484,025	271,531,249	347,762,172	343,595,169	72,063,920

Note: The variance of $76.2 million between planned spending and total authorities is mainly due to the operating budget carry forward, paylist reimbursement, and professional and special services related to payments with PHAC under the Shared Services Partnership Agreement. (refer to footnote 3 on page 27 for explanation of paylist requirements)

The variance of $4.2 million between total authorities and actual spending is mainly due to the changes in the timing of investment plan projects.

Human Resources (Full-Time Equivalents [FTEs])

2014-15 Planned	2014-15 Actual	2014-15 Difference (actual minus planned)
2,082	2,216	134

Note: The variance in FTE utilization is mainly due to the transfer of FTEs to Health Canada from PHAC which is associated with the health portfolio Shared Services Partnership model.

Performance Analysis and Lessons Learned

Health Canada worked to ensure that Canadians have access to the information they need to take action on their health and safety. Throughout the past year, numerous events, videos and social media initiatives were developed to support the Minister, as well as, to engage with and inform Canadians.

Health Canada increased the open and transparent access and exchange of information on Health Canada programs, policies and regulations by continuing to implement the Regulatory Transparency and Openness Framework and Action Plan, and by launching the Consultation and Stakeholder Information Management System.

Health Canada continued to move towards a common approach to regulatory risk communications by developing improved risk communications tools and mechanisms. Health Canada responded quickly and efficiently to the Ebola crisis and provided the communications response supporting the work of both Health Canada and PHAC.

Health Canada has also developed innovative communications products, services and channels including social marketing campaigns and initiatives to help raise awareness and knowledge of key health and safety such as Preventing Illicit Drug Use, Healthy Canadians Social Media, Tobacco Cessation, Ebola Recruitment, Antimicrobial Resistance, and Lyme Disease.

Through the Shared Services Partnership advances were made on government-wide modernization and transformation initiatives, including:

- Alignment with central agency direction to ensure readiness when these initiatives move forward for the deployment of a common e-mail platform, including a new Standard for E-mail Management, offering training sessions on managing e-mail effectively and regular e-mail messages to staff.
- Successful deployment of Windows 7 to network connected devices with the remaining devices.
- Assessment of all program areas for level of Record Keeping compliance in preparation for a Government of Canada records management system.
- Advancement in the migration of employees from landline to cellular technologies.
- Continued transition to a modernized workplace with projects to standardize and modernize work stations in various buildings in several regions.
- Successful testing of all systems related to a multi-departmental initiative (led by the Canada Border Services Agency) to implement a single window through which importers

can electronically submit information necessary to comply with government import regulations.

Health Canada undertook the following initiatives that served to improve internal processes and provide better services to Canadians and clients:

- Successfully transitioned PHAC to the new GCIMS in partnership with AANDC. All 2014-15 payments were processed using GCIMS payment module.
- Continued implementation of Health Canada's Resource Management Directorate modernization to continuously improve processes to support resource management and financial analysis within Health Canada.
- Implemented the on-going risk-based monitoring strategy for Internal Controls over Financial Reporting for Health Canada's and PHAC's common key controls related to financial statements.
- Initiated the Planning for Enterprise Performance (PEP) project. In 2014-15, the PEP project succeeded in demonstrating the feasibility and enterprise-wide value in transforming existing Health Canada operational and financial businesses processes and systems, to create a standardized planning and reporting environment that fully integrates both the operational and financial information requirements of stakeholders across the Department within Health Canada's SAP platform. They will result in high degree of alignment between financial and non-financial planning and reporting activities and priorities in Health Canada and partner departments.
- In support of the Shared Services Partnership, the new Shared Travel Services products and tools such as Government Travel Card, Online Booking Tool, Travel Expense Management Tool and Travel Agency Services were successfully rolled out to both Health Canada and PHAC.
- Successfully migrated from Oracle Financial to SAP as AANDC which went live with SAP and the interface linkages with GCIMS in fiscal year 2014-15.

Health Canada is a participant in the 2013-16 Federal Sustainable Development Strategy and contributes to Theme IV (Greening Government Operations) targets through the internal services program. Additional details on Health Canada's activities can be found in the Departmental Sustainable Development Strategy Supplementary Information Table[lix].

Section III: Supplementary Information

Financial Statements Highlights

Condensed Statement of Operations (unaudited) For the Year Ended March 31, 2015 (dollars)

Financial Information	2014–15 Planned Results	2014–15 Actual	2013–14 Actual	Difference (2014–15 actual minus 2014–15 planned)	Difference (2014–15 actual minus 2013–14 actual)
Total expenses	3,997,906,000	3,993,213,000	3,945,992,000	(4,693,000)	47,221,000
Total revenues	271,623,000	285,324,000	258,814,000	13,701,000	26,510,000
Net cost of operations before government funding and transfers	3,726,283,000	3,707,889,000	3,687,178,000	(18,394,000)	20,711,000

The Department's total expenses were $4.0 billion in 2014-15.

There was a decrease of $4.7 million when comparing actual expenditures to planned results for 2014-15. This is primarily a result of variances in accounting adjustments related to severance pay and contingent liabilities.

There was an increase of approximately $47.2 million when comparing year-over-year actual expenditures. The significant changes were:

- An increase of $96.5 million in transfer payments due primarily to disbursements made to the FNHA under the BC Tripartite Framework Agreement.
- An increase of $15.3 million in the cost of travel for non-insured health patients as a result of increasing costs of transportation and a higher demand experienced during the year as compared with the prior year.
- An increase of $8.2 million in utilities, materials and supplies reflecting an increase in expenses for pharmaceutical and medical supplies which are demand-driven and can vary from year to year.

These increases are offset by:

- A decrease of $16.4 million in salaries and employee benefits largely due to payments made during 2014-15 for retroactive adjustments and the liquidation of severance and termination benefits payable from collective bargaining agreement settlements signed in the previous year, offset by an increase in the provision for severance pay.

- A decrease of $16.6 million in professional and special services as a result of a reduction in the cost of nursing services through the establishment of centrally managed contacts for temporary nurses and the reduced utilization by regions of temporary nurses as a result of increased staffing levels.
- A decrease of $25.1 million in other expenses as a result of the reversal of a contingent liability allowance.

he Department's total revenues were $285.3 million in 2014-15 representing an increase of 26.5 million over the prior year actual revenues. This increase is primarily a result of:

- An increase of $31.2 million in services of a non-regulatory nature from the FNHA, reflecting a full year of operations under the BC Tripartite Framework Agreement to recover expenses for the NIHB Program.
- An increase of $8.2 million in services of a regulatory nature due to increased volumes of drug submissions for evaluation and annual fee increases for those evaluations.

hese increases are offset by:

- A decrease of $11.3 million in rights and privileges revenue due to changes in the timing of establishment licences experienced in the prior year.

ondensed Statement of Financial Position (unaudited)
s at March 31, 2015 (dollars)

nancial Information	2014–15	2013–14	Difference (2014–15 minus 2013–14)
tal net liabilities	546,779,000	651,229,000	(104,450,000)
tal net financial assets	281,644,000	262,364,000	19,280,000
epartmental net debt	265,135,000	388,865,000	(123,730,000)
tal non-financial sets	130,776,000	129,386,000	1,390,000
epartmental net ancial position	(134,359,000)	(259,479,000)	125,120,000

tal net liabilities were $546.8 million at the end of 2014-15, a decrease of $104.5 million from e previous year comprised mainly of:

- A decrease of $88.1 million as a result of payments to Canada Health Infoway Inc. drawing down the liability originating from the 2007 and 2009 Budgets.
- A decrease of $33.0 million for the reversal of an accrued contingent liability.
- Offset by an increase of $14.3 million in employee future benefits due to a change in the actuarially determined rate used to calculate the liability.

e year-over-year increase in total net financial assets of $19.3 million is primarily a result of increase in amounts due from the Consolidated Revenue Fund, reflecting changes in accounts yable and accrued liabilities.

tal non-financial assets increased $1.4 million resulting from capital spending as approved in main estimates, net of amortization.

nancial Statements

e financial statements including the Annex to the Statement of Management Responsibility luding Internal Control over Financial Reporting can be found on Health Canada's web site[lx].

upplementary Information Tables

e supplementary information tables listed in the *2014–15 Departmental Performance Report* be found on the Health Canada's website[lxi].

- Departmental Sustainable Development Strategy;
- Details on Transfer Payment Programs of $5 Million or More;
- Horizontal Initiatives;
- Internal Audits and Evaluations;
- Response to Parliamentary Committees and External Audits;
- Up-Front Multi-Year Funding; and,
- User Fees, Regulatory Charges and External Fees.

x Expenditures and Evaluations

e tax system can be used to achieve public policy objectives through the application of special asures such as low tax rates, exemptions, deductions, deferrals and credits. The Department of ance Canada publishes cost estimates and projections for these measures annually in the *Tax penditures and Evaluations*[lxii] publication. The tax measures presented in the *Tax penditures and Evaluations* publication are the sole responsibility of the Minister of Finance.

ction IV: Organizational Contact Information

rc Desjardins
ctor General
th Canada
ECTOR GENERAL'S OFFICE
Eglantine Driveway, Tunney's Pasture
wa, Ontario K1A 0K9
phone : 613-948-6357
613-946-0807
.desjardins@hc-sc.gc.ca

dix: Definitions

tion (*crédit*): Any authority of Parliament to pay money out of the
ed Revenue Fund.

expenditures (*dépenses budgétaires*): Includes operating and capital
s; transfer payments to other levels of government, organizations or
and payments to Crown corporations.

tal Performance Report (*rapport ministériel sur le rendement*): Reports on
ated organization's actual accomplishments against the plans, priorities and
sults set out in the corresponding Report on Plans and Priorities. These reports
Parliament in the fall.

quivalent (*équivalent temps plein*): Is a measure of the extent to which an
epresents a full person-year charge against a departmental budget. Full-time
are calculated as a ratio of assigned hours of work to scheduled hours of
luled hours of work are set out in collective agreements.

t of Canada outcomes (*résultats du gouvernement du Canada*): A set of 16
bjectives defined for the government as a whole, grouped in four spending
mic affairs, social affairs, international affairs and government affairs.

nt, Resources and Results Structure (*Structure de la gestion, des*
t des résultats): A comprehensive framework that consists of an
's inventory of programs, resources, results, performance indicators and
information. Programs and results are depicted in their hierarchical
to each other and to the Strategic Outcome(s) to which they contribute. The
t, Resources and Results Structure is developed from the Program Alignment
.

ary expenditures (*dépenses non budgétaires*): Includes net outlays and
ed to loans, investments and advances, which change the composition of the
ets of the Government of Canada.

e (*rendement*): What an organization did with its resources to achieve its
well those results compare to what the organization intended to achieve and
sons learned have been identified.

e indicator (*indicateur de rendement*): A qualitative or quantitative means
an output or outcome, with the intention of gauging the performance of an
program, policy or initiative respecting expected results.

ice reporting (*production de rapports sur le rendement*): The process of ating evidence-based performance information. Performance reporting ecision making, accountability and transparency.

pending (*dépenses prévues*): For Reports on Plans and Priorities (RPPs) and tal Performance Reports (DPRs), planned spending refers to those amounts e Treasury Board approval by February 1. Therefore, planned spending may ounts incremental to planned expenditures presented in the Main Estimates.

ent is expected to be aware of the authorities that it has sought and received. ination of planned spending is a departmental responsibility, and departments e to defend the expenditure and accrual numbers presented in their RPPs and

: The articulation of strategic choices, which provides information on how an n intends to achieve its priorities and associated results. Generally a plan will logic behind the strategies chosen and tend to focus on actions that lead up to d result.

priorité): Plans or projects that an organization has chosen to focus and report ne planning period. Priorities represent the things that are most important or be done first to support the achievement of the desired Strategic Outcome(s).

programme): A group of related resource inputs and activities that are meet specific needs and to achieve intended results and that are treated as a nit.

lignment Architecture (*architecture d'alignement des programmes*): A nventory of an organization's programs depicting the hierarchical relationship grams and the Strategic Outcome(s) to which they contribute.

Plans and Priorities (*rapport sur les plans et les priorités*): Provides on the plans and expected performance of appropriated organizations over a eriod. These reports are tabled in Parliament each spring.

ltat): An external consequence attributed, in part, to an organization, policy, initiative. Results are not within the control of a single organization, policy, initiative; instead they are within the area of the organization's influence.

xpenditures (*dépenses législatives*): Expenditures that Parliament has rough legislation other than appropriation acts. The legislation sets out the he expenditures and the terms and conditions under which they may be made.

me (*résultat stratégique*): A long-term and enduring benefit to linked to the organization's mandate, vision and core functions.

(*programme temporisé*): A time-limited program that does not have an and policy authority. When the program is set to expire, a decision must to continue the program. In the case of a renewal, the decision specifies g level and duration.

measurable performance or success level that an organization, program to achieve within a specified time period. Targets can be either alitative.

res (*dépenses votées*): Expenditures that Parliament approves annually priation Act. The Vote wording becomes the governing conditions e expenditures may be made.

ment framework (*cadre pangouvernemental*): Maps the financial ederal organizations receiving appropriations by aligning their Programs ernment-wide, high-level outcome areas, grouped under four spending

---

f Canada Secretariat, http://www.tbs-sct.gc.ca/
ct, http://laws-lois.justice.gc.ca/eng/acts/C-6/
r Product Safety Act, http://laws-lois.justice.gc.ca/eng/acts/c-1.68/
nmental Protection Act, 1999, http://laws-lois.justice.gc.ca/eng/acts/C-15.31/
and Substances Act, http://laws-lois.justice.gc.ca/eng/acts/c-38.8/
Act, http://laws.justice.gc.ca/eng/acts/F-27/
://laws-lois.justice.gc.ca/eng/acts/T-11.5/
cts Act, http://laws-lois.justice.gc.ca/eng/acts/H-3/index.html
als Information Review Act, http://laws-lois.justice.gc.ca/eng/acts/H-2.7/
alth Act, http://laws-lois.justice.gc.ca/eng/acts/H-3.2/index.html
g Devices Act, http://laws-lois.justice.gc.ca/eng/acts/R-1/
ucts Act, http://laws-lois.justice.gc.ca/eng/acts/P-9.01/
egulations, http://www.hc-sc.gc.ca/ahc-asc/legislation/acts-reg-lois/acts-reg-lois-

cts Regulations, http://laws-lois.justice.gc.ca/eng/regulations/SOR-2015-17/
Plan 2014 Act, No.1, http://laws-lois.justice.gc.ca/eng/annualstatutes/2014_20/
ans from Unsafe Drugs Act (Vanessa's Law), http://laws-
ng/annualstatutes/2014_24/page-1.html
egulations, http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._870/
arency and openness, http://www.hc-sc.gc.ca/home-accueil/rto-tor/index-eng.php
ion, http://www.hc-sc.gc.ca/fn-an/gmf-agm/appro/index-eng.php
/www.hc-sc.gc.ca/fn-an/gmf-agm/appro/arcapp-arcpom-eng.php
nent framework, http://www.tbs-sct.gc.ca/ppg-cpr/frame-cadre-eng.aspx
mates, http://www.tbs-sct.gc.ca/ems-sgd/esp-pbc/esp-pbc-eng.asp
Health Information Initiative, http://www.hc-sc.gc.ca/ahc-
val/2013-hii-iis-eng.php
ployee Assistance Services, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/eas-

s Act, http://laws-lois.justice.gc.ca/eng/acts/O-3.01/
: Drug Manufacturing Establishments, http://www.hc-sc.gc.ca/dhp-
conform/tracker-suivi-eng.php
roduct Inspections, http://healthycanadians.gc.ca/drugs-products-medicaments-
ns/index-eng.php?_ga=1.20935418.313288619.1429559008
lth Product Register, https://hpr-rps.hres.ca/search-recherche-eng.php
Food and Consumer Safety Action Plan 2008-2009 to 2012-2013, http://www.hc-
erformance/eval/2014-food_safety-alimentaire_securite-eng.php
nt for Industry – Review of Drug Brand Names, http://www.hc-sc.gc.ca/dhp-
_guide/2014-review-examen_drug-medicament_names-marques/index-eng.php
eviews, http://www.hc-sc.gc.ca/dhp-mps/medeff/reviews-examens/index-eng.php
Cells, Tissues and Organs for Transplantation Regulations, http://www.hc-
brgtherap/reg-init/cell/cto_regs_rias-reir-eng.php
tribution of Semen for Assisted Conception Regulations,
gc.ca/eng/regulations/SOR-96-254/
http://www.hc-sc.gc.ca/dhp-mps/brgtherap/applic-demande/guides/blood-reg-

on, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/biologics-biologiques-

egulations, http://laws-lois.justice.gc.ca/eng/regulations/sor-98-282/
ducts Regulations, http://laws-lois.justice.gc.ca/eng/regulations/sor-2003-196/
ement Policy, http://www.hc-sc.gc.ca/dhp-mps/prodnatur/legislation/pol/pla-
tion-eng.php

ducts Directorate (NHPD) six-month calendar of activities: January to June 2015,
ice.gc.ca/eng/regulations/C.R.C.,_c._870/
de, http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index-eng.php
ood and Consumer Safety Action Plan, http://www.hc-sc.gc.ca/ahc-
al/2014-food_safety-alimentaire_securite-eng.php
Handling Labelling for Raw Ground Meat and Raw Ground Poultry,
c.ca/fn-an/legislation/guide-ld/guide-cook-cuiss-meat-viand-eng.php
erized Beef, http://www.hc-sc.gc.ca/fn-an/legislation/guide-ld/mech-tenderized-
s-meca-eng.php
cation, http://healthycanadians.gc.ca/nutrition-fact-valeur-nutritive/index-
062751.313288619.1429559008
Obesity, http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/framework-cadre/index-

://www.healthycanadians.gc.ca/eating-nutrition/healthy-eating-saine-
nseils/interactive-tools-outils-interactifs/eat-well-bien-manger-eng.php?src=fn-

edium=banner_en&content=&campaign=topic_footer&wbdisable=false
tive Educational Toolkit, http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/educ-
se/index-eng.php
lbox, http://www.hc-sc.gc.ca/fn-an/nutrition/part/tb-bo/index-eng.php
ons, http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._869/
Bassinets Regulations, http://www.laws-lois.justice.gc.ca/eng/regulations/SOR-
ml
ical Purposes Regulations, http://laws-lois.justice.gc.ca/eng/regulations/SoR-
l
rug Strategy Community Initiatives Fund, http://www.hc-sc.gc.ca/ahc-
al/dscif-ficsa-eng.php
clear Test-Ban Treaty Implementation Act, http://laws-
g/acts/C-36.5/
Control Act, http://laws-lois.justice.gc.ca/eng/acts/N-28.3/
(1979), http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-

ealth Living and Health Child Development Clusters, http://www.hc-
formance/eval/hlhcd-evaluation-vsde-eng.php
nunicable Disease Control and management Programs, http://www.hc-
formats/pdf/performance/eval/fnih-eval-spni-eng.pdf
r for First Nations Act, http://laws-lois.justice.gc.ca/eng/acts/S-1.04/
nable Development Strategy Supplementary Information Table,
anadians.gc.ca/publications/department-ministere/hc-performance-report-2014-
nt-sc/supplementary-supplementaires-eng.php#a1
s, http://www.healthycanadians.gc.ca/publications/2014-15-health-canada-
nance-report/financial-statements-etats-financiers-eng.php
rmation Tables, http://www.healthycanadians.gc.ca/publications/2014-15-
tmental-performance-report/supplementary-supplementaires-eng.php
d Evaluations publication, http://www.fin.gc.ca/purl/taxexp-eng.asp